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## Original Communications.

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### THE QUESTION OF RELATIONSHIP BETWEEN LICHEN PLANUS (WILSON) AND LICHEN RUBER (HEBRA).\*

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WITHIN the last few years a great deal has been written upon the clinical characters of the two forms of eruption designated by some as lichen ruber planus and lichen ruber acuminatus, and by others as lichen planus and lichen ruber, and the question of a relationship between them, both clinically and etiologically, has been a theme of much discussion and some difference of opinion. In this paper I wish to consider the clinical symptoms, histology, prognosis, and the results of treatment by similar drugs of the two forms of eruption described respectively by Wilson as lichen planus and by Hebra as lichen ruber, and from these endeavor to arrive at a conclusion as to the existence or non-existence of a relationship between them. At the same time, I wish to communicate the result of some studies in lichen planus which perhaps have no bearing on the subject of the paper, but which may add something to our existing knowledge of this special form of eruption.

In 1883 ("Lichen Ruber and Lichen Planus," "New York Medical Record," 1883) I wrote an article upon this same question of relationship between the two forms of eruption, and attempted to prove, from the symptoms, course, prognosis, and results of treatment by certain drugs, that they were in no essential characters related, and that they represented two

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\* Read in part before the American Dermatological Association at the Congress of American Physicians and Surgeons in Washington, 1888.

entirely different diseases; but, judging from the subsequent literature upon this subject—and the amount has been very considerable—the arguments I brought in evidence were not of a very convincing character to others, for, with the exception of two writers, the two forms are still regarded in Europe as the result of the same aetiological factor, whatever that may be. In America, Dr. Piffard was the only author who at that time denied a relationship, and, in the classification and nomenclature adopted by the American Dermatological Association, they are placed as varieties of one disease. That American dermatologists, however, have changed their views lately upon this question is shown by the unanimity of opinion at Washington, last September, at the annual meeting of the American Dermatological Association, that lichen planus and lichen ruber are two different diseases.

In my previous article I committed the error of quoting from the second edition of Hebra's work the description of lichen ruber, instead of from the first edition, as I did not possess a copy of the latter. The error was perhaps a pardonable one, as Hebra described in his second edition a flat form of lesion as though it was a common part and partner of the acuminate form described in his first edition; and, as at that time he alone had had sufficient experience with lichen ruber to describe with any completeness its clinical characters, I naturally copied his description, not imagining that he was endeavoring to incorporate a form of eruption first described by Wilson with the disease previously described by himself, although it is perhaps a question if he was familiar with the form of lesions characteristic of lichen planus. Had he mentioned Wilson's name in connection with the flat form of papule he described, the error would not have been committed; but this imperfect description—in my opinion imperfect, as I do not believe in a union of the two forms of eruption upon the same person, or, as I would express it, of the two diseases—in no wise interfered with the validity of the arguments advanced in my article, for they were based upon a study of pure cases of the eruption described by Wilson, and from the description of the first fourteen cases of lichen ruber described by Hebra, together with one case seen by myself. The described differences in the anatomy of the two forms of lesion were conclusions from observations made by myself on typical classical cases of both forms of eruption, and from a study of the descriptions and drawings of sections given by other observers.

In a recent work on dermatology by Dr. Jamieson, of Edinburgh, in discussing the pathology of lichen ruber (he describes lichen ruber and lichen planus as constituting one disease) he states that it can not be at all regarded as settled, and that my observations are confusing on the ground that I regard lichen planus and lichen ruber as quite distinct diseases, and consequently described the histology of the two forms of lesions

separately. This latter is surely a strange criticism to make, for it seems to me that confusion can arise only when the different forms of lesion are confounded with each other, and described without further specification as to form, age, etc., and the reader knows not whether a recent or old, an acuminate or a flat, papule is being described. He who would describe the changes in a macular and in an ulcerating syphilide, for instance, under the head of changes in the skin in syphilis, without separating for purposes of description the two forms of eruption and describing the changes separately, would certainly confuse the reader; and, if this be true in the case of lesions having a similar ætiological factor, and representing but different stages of the same disease, it must also be true in the case of lichen planus and lichen ruber, even if the two forms of eruption represent but different forms of the same disease. If, however, the question for argument is one of identity or non-identity of origin—and that was the question in my paper at the time the anatomical changes were described—it is absolutely necessary to consider the structure of the lesions separately, and, even if their identity in origin should be subsequently proved, the separate description of the lesions could not be confusing. So, also, to avoid confusion, the structure of recent and old lesions of the same disease should be studied and compared if we are to learn the primary and secondary changes which occur in any given cutaneous lesions, especially in those in which there occur marked changes in the circulatory apparatus of the part.

Apart, therefore, from the question of correctness or incorrectness of the description given of the histology of the lesions, it is clear that a separate description of the flat and acuminate lesions as made by me could not lead to confusion to others even if the conclusions I drew from them should prove to be incorrect. The statement made by Róna in the "*Monatsheft f. praktische Dermatologie*" in a recent article, that I had declared the two forms of eruption to represent entirely different diseases, and in no way related to each other, from conclusions formed by the microscopical examination alone of a single case of lichen ruber, is as carelessly made as many others in that same article, for those who have read my article must admit that I denied their identity because I was convinced that the symptoms, course, histology, prognosis, and results of treatment by similar drugs were so markedly different that the two forms of lesions could not have a similar origin or be related to each other in any way.

If it can be shown that the primary histological changes in lichen planus and lichen ruber are different both in anatomical seat and in character, the proof that the lesions have a similar ætiology must be shown before they can be regarded as but different forms of the same disease. If the anatomy of the lesions and the symptoms accompanying each form are different, the upholders of the doctrine of unity, as regards ætiology, must

show a tendency to transition of one form into the other form, or a simultaneous appearance of both forms upon the body; or, finally, that they both depend upon the same ætiological factor, be that factor an organism or some anatomical change in the nervous or other system not parasitic in origin.

As the ætiology of the two forms of eruption is at present unknown, the question of a conversion of one form of lesion into the other form; the conversion of a flat papule into an acuminate one and *vice versa*; of the simultaneous appearance of both forms upon the same person; of the change of form in successive attacks of the disease; and of the similarity in the symptoms and course of the disease in both forms—these are the subjects which I wish to discuss and, from the evidence obtained from their consideration, endeavor to show that lichen planus and lichen ruber are entirely different diseases. After a full consideration of the above questions I will endeavor, furthermore, to show that, from the histology of the lesions alone, there are no grounds for considering them to be produced by the same ætiological factor.

A sufficient number of typical cases of lichen ruber have been seen, since Hebra first described it, for the symptoms and course of the disease to be fairly well known. At the recent meeting in Washington, Dr. George H. Fox reported the histories of five cases, some of which I have seen, and Dr. R. W. Taylor reported two cases under his own care. As regards lichen planus, it is by no means an infrequent disease in America, and every dermatologist of experience in this country must have seen a considerable number of cases. I have conversed with some New York dermatologists on the subject, and they agree with me as to its frequency, so that the clinical history of this disease, drawn as it is from hundreds of cases seen in this country, is already well established and probably complete. The value of the unanimity of opinion among American dermatologists on the symptoms and prognosis of this disease will appear when we discuss the relationship this forms with lichen ruber.

It has been stated by some writers that Hebra's description as drawn from his first fourteen cases is imperfect, and represents only the characters of advanced and severe examples of the disease; but does he not distinctly describe how new lesions form, how the eruption extends, etc., in fact, the whole course of the disease to a fatal termination? That is, he so describes the natural history of his cases that any dermatologist of experience, after reading his description, would likely recognize at first observation an example of the disease.

Whether the cases described by Unna, Boeck, Lavergne, and others were examples of this disease or not is a question of much importance, and must be carefully considered in forming an opinion on the subject of this paper.



With all due respect for the views of other dermatologists and feelings of admiration for diligence and good valuable work, it remains the privilege and duty of every one to criticise with honesty and as much ability as he possesses any opinion or new views upon subjects put forth by co-workers. If we question the diagnosis of an expert in a given case, we must give the reasons for our difference of opinion and refusal to accept evidence from such a case, thus showing our desire to be honest and fair in argument. And, on the other hand, the author criticised must not consider himself infallible and his diagnosis a something under no conditions to be doubted, for a critic has just as much right to make a diagnosis from the written description of a case as the reporter of the case from the living subject. So, if in the following pages we differ in diagnosis from the opinion of our equals in dermatology, it will be not without a firm belief in the correctness of our view and an honest desire to arrive at a correct solution of the question being discussed.

In this paper no attempt will be made to give a complete account of the symptoms of either lichen planus or lichen ruber, but only such characters will be described as are necessary for the discussion of the subject of the paper.

According to Erasmus Wilson, lichen planus is a disease of the skin characterized by the formation of papules remarkable for their color, shape, tendency to arrangement in groups, situation, local and chronic character, and the pigmentation they frequently leave when they subside. As our knowledge of the disease has increased since he wrote upon the subject, I will add to his description or modify his statements according to the experience of the present day. Lichen planus is such a frequent disease in America—certainly several hundred cases have been seen and studied by American dermatologists—that its clinical symptoms, course, and tendencies are sufficiently well understood to enable one to discuss the question of any relationship between it and the disease described by Hebra as lichen ruber.

In the description of the eruption I will follow the order of characteristics as given by Wilson:

*Color.*—The color of the lesions in very small and of recent papules is a light red, which soon assumes a duller red, frequently suffused with a purplish tinge, and when of long standing or arranged to form patches, they are of a duskier hue. If the part occupied by the lesions is in a condition of passive hyperæmia, the papules have usually the dusky-red hue well marked, while in isolated lesions on non-dependent parts the color assumes at most a dull red. In many cases the color resembles exactly that present in a papular syphilide, while in others it is similar to that of eczematous or other cutaneous lesions.

*Shape.*—When very small the lesions are round in form, or nearly so, but

when larger they are generally more or less angular in outline and rise abruptly from the skin. They vary in size from that of a very small pin-head to that of a split pea or somewhat larger, are slightly elevated above the level of the general surface, and have a smooth, flat, shining surface which sometimes shows a depressed center. This umbilicated condition of the lesions is not so frequent as one would imagine from reading Wilson's description, and in many cases, although the number of lesions present may be considerable, it is absent in all of them. I am not aware that it has been seen in lesions situated on a mucous surface. In the few cases of lichen planus which I have seen with the eruption upon the palms of the hands, the lesions were sharply limited and dark red in color, but were slightly, if at all, elevated and not so angular in form as when situated on other parts of the cutaneous surface. If any isolated lesions are situated around a hair follicle—an unusual occurrence—they are roundish in form and may be covered with a small scale, thus bearing a close resemblance to the lesions present in some cases of perifollicular eczema.

In the most recent and in small isolated lesions the surface is shining and devoid of scales, with the rare exception mentioned above; but in older and larger papules there appears to be a thin layer of horny transparent cuticle present. I am not aware that marked scaliness has ever been observed on isolated pea-sized lesions; but when the eruption is diffuse and the papules closely situated so as to form a patch in which the interpapular skin has become implicated in the pathological process, there is generally desquamation and scaling, especially if the part has been irritated or is situated on the lower extremities. Where the patch is made up of more or less incompletely isolated papules, the amount of scaling may be very slight or even absent. In one of my cases in whom the eruption existed several years upon the knee the scaling was very slight indeed; in fact, could be described as being absent. (See Fig. I.)

When scaling is well marked and there are no lesions outside of the scaly patch, it may be impossible to diagnose the disease from a patch of psoriasis or of chronic scaly eczema of the leg in a gouty or rheumatic subject, especially if passive hyperæmia is present.

*Course.*—A pin-head-sized papule usually increases in size by peripheral extension until it is as large as a split pea or larger. When situated on a mucous surface of the mouth or on the glans penis there does not seem to be the same limit to its amount of extension; at least the long, narrow patches of infiltration seen in these regions can not always be traced to a coalescence of previously isolated lesions. Wilson states that the lesions do not increase in size subsequent to their first appearance on the skin, but the growth in size of individual papules from a pin-head-sized to a split-pea-sized lesion is a frequent—I should say, I believe, a usual—occurrence; that is, that the larger papules were previously small ones.

An extension of the primary lesions to form patches in the manner observed in psoriasis does not in my experience occur unless it be on the mucous membrane of the mouth, on the penis, or on the lower extremities. In the two latter situations I have seen and studied for a length of time patches which seemed to spread in that manner—at least, I was unable to detect at the spreading periphery any signs of new papules forming; the only symptoms were those of a gradually extending inflammatory infiltration.

When patches form, they are sharply limited, elevated, violet or bluish-red or dark-red in color, and usually covered more or less with scales, although, as already mentioned, the latter are not always present. The skin beneath the scales is often uneven, warty in appearance, and occasionally, especially in long-standing cases, are to be seen in greater or less number white, milium-like, pin-head-sized spots which can be dug out, and, when examined, are found to consist of epithelium. Sometimes as many as a dozen of these white spots can be seen in a large pea-sized papule. They have been described as situated in follicle orifices, but we will see later on that that view is not a correct one. In Fig. II of colored drawing, a number of these whitish bodies can be seen in the upper left part if the drawing is closely examined. The chronic thickened patches correspond to the *lichen hypertrophique* and the scaly ones to the *lichen corné* of French authors (see Fig. I). The term *lichen verrucosus* has been applied to the chronic form of the disease when the lesions show great thickening and induration of the skin. In these cases the surface may be like plush (Jamieson), or rough and horny, and the scales are firmly adherent.

The life-duration of individual papules is usually a long one, and I have had patients who maintained with positiveness that they have seen lesions lasting for years before disappearing. When they subside they usually leave pigmentation and atrophy of the part behind; but if the lesions are small and their life-duration comparatively short, this condition may not result.

*Arrangement.*—The papules are either discrete or aggregated, but they generally show a tendency to form groups. Occasionally they are arranged as broader or narrower, larger or shorter bands. In one of Kaposi's cases the arrangement of the papules to form bead-like rows was very remarkable. Lesions show a tendency to form where the skin has been injured by scratching or friction, so that it is not unusual to find lesions arranged in a bead-like form along a red line corresponding to the part scratched. As the result of scratching we also see, not infrequently, lesions of an eczematous character, but these are of short life-duration and give evidence of the occurrence of serous exudation from the blood-vessels. The serous exudation resulting from scratching may be sufficient to produce bullæ. They have been described as an occasional symptom of the disease and

arising independent of external irritation, but I have never seen them arise except from the above-named cause. They are observed especially in connection with old, thickened, non-scaly patches formed by large papules.

In addition to the large and small papules previously referred to, Unna describes, under the head of lichen planus proper, lesions of considerable size which are but slightly, if any, elevated above the general surface, and are sharply limited. He thinks they can assume this form *d'emblée*, instead of by aggregation of small papules. All who have seen many cases of lichen planus must have observed such shaped patches or lesions, but I do not think that they represent a special form of the disease, as they arise, usually at least, from a coalescence of very small papules, the most recent lesions arising at the periphery of the patch and thus causing it gradually to become larger. As, however, papules can be produced by external irritation, there are no reasons why a patch the size, say, of a fifty-cent piece should not suddenly form from the same cause. For myself, I have not seen a patch form thus suddenly, but if it does occur that would, to my mind, be no reason for making this form of lesion a special form of the disease, as I believe that in the majority of cases it is produced by an aggregation of small papules.

As the papules in this disease have no definite size or form, but all the forms and sizes above described are usually met with on the same person, it seems to me that the term lichen planus as employed by Wilson is preferable to the division made by Unna into lichen planus and lichen obtusus.

*Situation.*—The eruption is generally symmetrical and appears especially upon the anterior surface of the forearms, just above the wrists, but it may appear upon any part of the body, and especially upon the lower part of the abdomen, the calves of the legs, and anterior surface of the knee. It has been observed upon the mucous membrane of the mouth, tongue, and fauces.

The eruption is not only sometimes not symmetrical, but it may remain limited to a single spot or to one side of the body for a length of time before appearing elsewhere. In one of my patients the eruption was confined to one knee for more than four years.

The disease rarely if ever attacks the nails. One of the cases reported in which this was said to have occurred was that of a washerwoman, and we all know the liability of their nails to abnormal conditions from their occupation. Tontou ("Kasnistisches zum Lichen ruber planus der Haut und Schleimhaut," "Berl. klin. Wochenschr." 1886, No. 23) describes a case in which the eruption was very severe on the hands, but the nails remained unaffected. I have no doubt but that a number of such cases could be reported. There are no reasons, probably, why the nails should remain unaffected, but there is certainly no tendency of the disease to

invade these structures, no matter how extensive the eruption may be on the rest of the body.

*Course.*—The course of the eruption is very chronic, and the disease may remain limited to a small region of the body for many years, and finally disappear without showing any tendency to extend to other parts. In one of my cases the eruption existed on the scrotum eighteen years, and upon the knee and one ankle for a shorter period. Sometimes the eruption spreads rapidly over a large area, as in the following case: Sarah L., aged thirty-two, married. Eruption commenced three months ago on the arms, back, and lower extremities. On the right arm there are from fifty to sixty lesions, mostly upon the flexor surface, and varying in size from that of a pin-point to that of a small pea. The smallest ones are round in form, and have a well-marked shining surface. As the lesions become larger they are irregular in shape. A large number even of the smallest lesions show a depressed center. In some of the large ones there is a visible sinking in of the central portion of the lesion. No acuminate lesions are present. Some of the larger lesions showed a slight tendency to scaling. On the left arm similar lesions to the above-described ones are present. Upon the back there are probably a couple of hundred lesions irregularly distributed or arranged in groups or rows. The majority have a depressed center, and there are no acuminate lesions. Only a few papules are present on the anterior surface of the thorax, and the face and neck are free. Upon the lower extremities the lesions are situated on the leg and lower part of the thigh. They are larger than those upon the upper extremity, are darker in color, not so grouped or sharply limited, have no depressed center, and are not so flat. Slight scaling is to be observed in some cases. On the right leg, at the inner side of the knee, there is a large, irregularly shaped, sharply limited, red, elevated, and non-scaling patch composed of many primary lesions with shining surfaces. On the leg there are many lesions of variable size, not always sharply limited, and of a reddish color, the redness disappearing somewhat upon pressure. In one place there is a patch where the epidermis is much thickened and the surface has a warty appearance. In a few months the eruption disappeared without the use of arsenic or any local application. Her general health showed no signs of deterioration. Her physical condition was excellent; she was an example of the class of the apparently well-nourished German women familiar to New York physicians.

It has been stated by some writers that the general health is frequently affected in cases of lichen planus. My own experience, which agrees with that of all dermatologists in America with whom I have spoken upon the subject—and this combined experience must include a large number of cases—is that patients affected with this disease are as well nourished and otherwise in as good physical condition as the subjects of any other skin-



disease; that is, they rarely complain of anything except the skin affection, and, if they do complain, the condition is certainly not the result of a marasmic condition; and, furthermore, I have never seen a case, and my friends have not seen a case, no matter how long the disease has lasted, in which there was any danger of a marasmic condition resulting from or in connection with the condition causing lichen planus. As will be referred to later on, a number of my patients have had rheumatism or suffered from malarial infection, and I have attributed the predisposing cause—at least, in certain cases—to one or other of these conditions; but the lichen planus had for me no more serious import than if the eruption had been an eczema in connection with similar conditions.

The prognosis, then, in untreated cases of this disease is absolutely favorable as regards the general nutrition of the subject; there is no special tendency to its becoming general over the body, and there are no reasons for supposing it to have any relation to grave nutritive conditions of the system, or that it causes such conditions of the organism.

In reviewing the symptoms of the disease as briefly given above, we find that a diagnosis of lichen planus can not *always* be made from the color, grouping, or shape of the individual lesions alone, but that in difficult cases all the characteristics of the disease, including the life-duration and the pathologico-anatomical course, must be taken into consideration. The presence of a few papules—red in color and angular in shape—upon the skin, for instance, does not justify one in saying that the disease lichen planus is present any more than the presence of a diphtheritic membrane upon a wound justifies the view that the infectious disease diphtheria is present. The diseases with which it is specially liable to be confounded are syphilis and eczema. In a papular syphilide the color, situation, grouping, and shining character of the surface of the lesions may be similar, and a positive diagnosis be impossible at the first observation of the patient. Such a case was recently exhibited at a meeting of the New York Dermatological Society, and, although the number of lesions was very great, the members of the society were divided in opinion as to whether the case was one of syphilis or lichen planus. This case proves conclusively that the lesions of syphilis and lichen planus may be exactly similar in objective characters.

A follicular eczema of the lower extremities, especially in old persons with a feeble peripheral circulation—a passive hyperæmia—of the part, is often characterized by lesions very similar in appearance to those of lichen planus of this region, the color, arrangement, itching, rarity of vesicle-formation, and chronicity of the disease making the similarity sometimes very great and the diagnosis difficult. Cases which I would call undoubted cases of follicular eczema have been under my observation and treatment after having been treated for many months by other capable dermatolo-

gists of much experience for lichen planus. In these cases I did not make the diagnosis from the color, size, or shape of the lesions alone, but upon the anatomical seat and the life-duration of the individual lesions. In eczema the life-duration of a single lesion is not long; the existing lesions tend to disappear after a few days, and new ones arise. It is also unusual for isolated lichen-planus lesions to form around hair follicles. Furthermore, in eczema the lesions are rarely so localized as in lichen planus, and there is not the tendency to grouping of the lesions as observed in the latter. Nevertheless, the lesions may be grouped, and have the other objective characters of the lichen-planus lesions, and a diagnosis be impossible unless it be by studying the life-duration of the single lesions.

A *single* patch of chronic scaly lichen planus situated upon the leg may resemble exactly a patch of chronic scaly eczema or a patch of psoriasis. The diagnosis in this case is to be made by a history of the case and a study of the rest of the body. That the patch alone can not be diagnosed shows that the lesions of lichen planus are not peculiar to the disease.

As regards the shape of the papules of lichen planus, they are not always angular in outline and umbilicated, but they may be roundish and have a perfectly flat or slightly rounded surface; but, even when angular in outline, and with a depressed center, that form is not pathognomonic of lichen planus. I have frequently observed, especially upon the flexor surface of the forearms, near the wrist, an eruption of acute inflammatory papules, round or angular in outline and with a pin-point-sized depression in the center, which, from the history of the case and a study of the course of the lesions, could not be regarded as a lichen planus, but as an eczema, the lesions being situated probably around an excretory sweat-duct outlet, and the inflammation not intense enough to produce vesicles. In this case the short life-duration of the lesions and an examination of the rest of the body enable one to make a diagnosis sooner or later. There are other examples of eczematous lesions met with in old rheumatic or gonty subjects, and in younger fleshy persons who sweat considerably, in which the eruption resembles the large flat papules or small patches of lichen planus. These lesions I have seen principally upon the face and back of the hands, and, although I have always excluded the disease lichen planus in these cases, the reasons for doing so were sometimes not very definite, the opinion being more the result of experience from previous cases than formed from the character of the lesions at the time.

In a pure papular eczema there may be many of the lesions resembling in all objective characters papules of lichen planus, as in the following case:

A. B., boy, aged seven years. Eruption appeared eight days ago and occupies face, trunk, and extremities, being greatest in amount upon the face

and extremities. The eruption was papular throughout and no vesicles were to be observed, although there were several hundred lesions present. The itching was severe. Appearance of eruption : On the back of the right hand there is a number of lesions the size of a pin-head or larger. The small ones are elevated, sharply limited, have a flat, shining surface, and occasionally a small depression in the center. Some of the larger lesions are irregular in outline, and have a flat, shining surface and a depressed center. They are sharply limited, deep-red in color—not violaceous. Mixed with these flat lesions are acuminate papules of similar size. On the extensor surface of the forearm there is a greater number of lesions, and, as a rule, they are larger than those upon the hand. The majority of them are acuminate and some are covered with a blood-crust caused by scratching. Some of the papules are polygonal-shaped and have a flat, shining surface, and occasionally a central depression can be observed. The left arm and hand presented similar lesions to those upon the right. The flat lesions in some places were grouped and in other places irregularly distributed among the other lesions. As regards the objective characters, these flat lesions resembled exactly the smaller lesions of lichen planus. Upon the cheeks and forehead there was a large number of papules, all more or less acuminate, and those upon the forehead showed but slight inflammatory redness. On the legs the lesions were similar to those upon the arms. Upon the left knee were several polygonal-shaped lesions with a flat and very shining surface.

Here was a case of undoubted lichen simplex or papular eczema, whichever you choose to call it, and yet there were many lesions present which resembled exactly lesions observed in lichen planus, even if there were no distinct obtuse lesions with a violaceous tinge.

Finally, a disease with an acuminate papular eruption on those parts of the body where the corneous layer is thin may appear as flat papules where this layer is thick, as on the palms of the hands and the soles of the feet. A case of lichen ruber of Hebra has been reported as showing a union of this disease with lichen planus, because upon the palms and soles the lesions were flat. Such a case certainly is no proof of a union between the two diseases.

Knowing what a frequent disease syphilis is, and knowing also how frequent eczema is, and having learned how closely the lesions of these two diseases may resemble those of lichen planus—so closely that from the objective characters of the lesions a diagnosis can not always be made—one must admit, it seems to me, the mistake of regarding the presence of a few papules of the form and color of the lesions of lichen planus as proof of the existence of this special disease, especially if they are situated in unusual situations for this disease. If the symptoms, arrangement, situation, course, etc., of the lesions are such that the diagnosis of lichen planus should be made, then, if found in connection with an undoubted case of lichen ruber of Hebra, that would be proof of the presence of the

two forms of eruption—the two diseases—upon the same person. Of course their conjoint presence would not be any proof of similarity of aetiology any more than the presence of eczema and syphilis upon the same subject.

In my opinion, then, the presence of dark-red, round or polygonal-shaped, flat papules, with or without a depressed center, and which show no tendency to become vesicles, justifies the diagnosis of a lichenoid eruption, but not of the disease lichen planus. For the latter diagnosis the clinical symptoms must correspond with those of undoubted cases of the disease. This is a point upon which I wish to lay much weight, for in some of the cases reported in which lichen planus has been reported as existing in connection with lichen ruber the lesions did not correspond, as regards number, situation, grouping, etc., with those of ordinary lichen planus, and consequently, in my opinion, should not be accepted as examples of that disease when discussing this question of relationship.

The same difficulty will be encountered when we come to discuss the significance of acuminate scaly lesions.

*Prognosis.*—In untreated cases the disease may last many months or years, but it never shows any tendency to produce a marasmic condition of the system or to lead to a fatal result. The eruption also is inclined to remain localized and not to extend over a large area or become general over the cutaneous surface. When it does extend over a considerable surface the general health does not seem to be more affected than when the disease remains localized. It shows no tendency to attack the face, hair, or nails, although by that statement I do not wish to maintain, as some authors would have it that I do, that these parts are absolutely exempt from the eruption.

*(To be continued.)*

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#### SYCOSIS: A CLINICAL STUDY.\*

By GEORGE THOMAS JACKSON, M. D.,

Assistant Physician, New York Skin and Cancer Hospital.

GENTLEMEN: It is a good thing to go over one's cases from time to time and to find out how much or how little one has accomplished in the treatment of the various diseases that have come under one's observation. Sometimes he may be surprised to find that he has accomplished so much, and sometimes he may be humbled by discovering that his most conscientious endeavors have been futile. I ask your indulgence to-night while I relate my experience in the treatment of sycosis.

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\* Read before the New York Dermatological Society, November 27, 1888.

All of you will probably agree in the opinion that sycosis is one of the most obstinate of skin diseases. It has proved itself, in my hands, a most difficult disease to manage. What I offer you to-night is no story of brilliant cures, but a candid statement of difficulties struggled against; and is brought before you in the hope that it may serve to bring out in the discussion some suggestions as to treatment from some of you who are older or wiser than I.

My cases number twenty-two. Ten of the patients were between twenty and thirty years of age, nine between thirty and forty, two between forty and fifty, and one between fifty and sixty. The earliest age was twenty-three—three cases. The oldest patient was fifty-four.

As to nationality, twelve were from the United States, four were German, one Austrian, one Russian, one Pole, and two Irish.

As to occupation, five of them were tailors; four, clerks; one was a car-starter; one, an engineer; one, an upholsterer; one, a boiler-maker; one, an elevator boy; one, a salesman; one, a cigar-maker; one, a hatter; one, carpets; one, a druggist; and three had no occupation.

The duration of the disease before coming under treatment was as follows: In one case, fifteen years; in one, twelve; in one, ten; in one, seven; in two, six; in two, four; in one, three; in three, two; in one, one year and three months; in one, eleven months; in one, nine months; in one, six; in one, five; in one, four; in two, three; in two, two.

The location of the disease was as follows: Upper lip alone, six cases; upper lip and chin, two; upper lip and cheeks, one; upper lip, cheeks, and chin, five; cheeks alone, three; cheeks and lower lip, one; chin alone, two; one cheek alone, one; whole bearded face, eyebrows, and scalp, one.

Digestive disturbances were noted in seven cases; nasal catarrh in four cases in which the upper lip was involved.

In only fourteen of the cases was I able to observe the effect of treatment long enough to be of any value in a study of this sort. As most of the cases were dispensary patients, the results are, perhaps, not so good as they might have been in those of a better class. Allow me here to give a short account of the treatment in the fourteen cases:

1. Sept. 27, 1882. Began treatment by epilation and the use during the day of a solution of hydrarg. bichlor., gr. j to  $\frac{5}{8}$  j; while at night the patient was directed to wear upon the affected parts an ointment of ungt. hydrarg. ammon.,  $\frac{3}{4}$  j; ungt. zinci oxid.,  $\frac{5}{8}$  j. M. Fowler's solution was given by the mouth. Local treatment for rhinitis.

Oct. 2. No better. The patient was directed to use soap frictions once a day. The other treatment was continued, excepting that diachylon ointment was substituted for the ammoniate of mercury and zinc oxide.

Oct. 15. Much better. Stop bichloride wash.

Nov. 4. Stop frictions with soap. Substitute Bronson's ointment (hg.



ammon., ℥j; calomel, ℥ij; vaseline, ℥j; M.) for the diachylon. Apply solution of caustic potash (gr. xx ad ℥j) to a few spots.

Nov. 8. Spots touched with caustic decidedly better. Repeat.

Nov. 15. As before. Paint all with caustic.

Dec. 10. All well but small patch on each cheek.

Dec. 24. Slight relapse.

Feb. 12, 1883. Disease still continues. Paint with iodine.

Feb. 20. No better. Curetted right side, after which applied Lassar's paste.

Feb. 27. Right side improved. Curetted the other side.

March 6. Decided improvement. Repeat.

March 21. Relapse.

May 6. Better. Some places nearly well.

2. March 10, 1883. Epilate and curette right cheek and use protective ointment.

May 14. Have continued curetting on both sides, and latterly have used Bronson's ointment. Very much better than at first, but not well.

3. Feb. 8, 1884. Epilate. Direct to shave. Ungt. diachyli. Local treatment for nose.

Feb. 12. Calx sulphurata, gr.  $\frac{1}{10}$ , every two hours.

Feb. 16. Less red and swollen. Stop calx.

Feb. 23. Worse. Spreading. Stop diachylon and give white precipitate ointment. Renew calx.

March 3. Great improvement. Stop calx.

March 11. Nearly well. No pustules.

June 25, 1884. Relapse.

May 28, 1884. Diet. Shaving. Lassar's paste with salicylic acid. Calx, gr.  $\frac{1}{10}$  every hour.

July 22. Writes me that pustulation has entirely ceased, but some redness remains.

4. May 9, 1885. Began with a four-per-cent. salicylated oil, which used for three days. Then epilation, hot water locally, and Bronson's ointment for one month. Patient made steady improvement.

5. May 16, 1885. Treated for two months with oil of cade, ℥ij, in olive-oil, ℥j, with steady improvement but no cure.

6. April 29, 1886. Local treatment for rhinitis, and laxatives as needed. Epilation, shaving, and Lassar's paste with salicylic acid up to June 29th. Steady but slow improvement.

June 29. Ichthyol, 10-per-cent. solution externally, and three grains twice a day internally.

July 10. Growing constantly worse. Stop ichthyol externally and use Lassar's paste with salicylic acid.

Aug. 31. From the time of stopping ichthyol to the present date has been doing well. He disappeared for some months and then called in great glee to show me how he had cured himself with a strong sulphur ointment he had made for himself.

7. May 1, 1886. Diet. Ungt. diachyli. Calx, gr.  $\frac{1}{4}$  t. i. d.

May 25. Stop diachylon and use sulphur loti, 3 ss. to ʒj of lard. Calx, gr. ¼ every two hours.

June 19. No new pustules for some days. Continue treatment.

Oct. 24. Relapse after being nearly well.

8. Jan. 27, 1887. Ungt. ac. boracis, 5 per cent.

Jan. 29. Increase strength of boric acid to 20 per cent. Ext. hamamelis fld., ten drops t. i. d.

March 8. Made great improvement up to this date, when he had a relapse. Put on sulphur, 3 ss. to ʒj of lard.

April 9. Nearly well.

June 18. Relapse.

9. Jan. 29, 1887. Equal parts of sulphur ointment and simple ointment. Internally, fld. ext. hamamelis, ten drops t. i. d.

No improvement after three weeks' use of above treatment. Stop it and give a 20-per-cent. boric-acid ointment and internally calx sulphurata, gr. ⅙ every hour.

March 12. Greatly improved.

10. Feb. 3, 1887. Epilate. Ungt. ac. boracis, 20 per cent.

March 19. No better. Stop boric acid and use sulphur, 3 j ad ʒj of lard.

April 16. No pustules.

May 14. Stop sulphur and use an ointment of tar and oxide of zinc.

July 2. Is practically well.

May 2, 1888. Relapse three weeks ago after having been entirely well for months.

June 9. Is nearly well again.

11. Aug. 13, 1887. Ungt. sulphuris. Tab. trit. sulphur., gr. ½ t. i. d.

Sept. 10. No better. Stop sulphur ointment and use mild white precipitate ointment.

Oct. 11. No improvement.

12. Dec. 13, 1887. Epilation. Resorcin, 3-per-cent. ointment. Local treatment for nose.

Jan. 10, 1888. No improvement.

13. Nov. 27, 1887. Diachylon ointment. Iron, arsenic, and strychnine internally. Hot-water fomentations. Epilation.

Dec. 16. Cured.

14. Feb. 25, 1888. Epilate. Resorcin, 3 per cent. in ointment.

March 19. Not much change. Substitute diachylon ointment for the resorcin.

March 29. No better. Stop diachylon and use a 3-per-cent. salicylated oil.

April 5. Worse. To use Lassar's paste and hot water.

April 7. Calx sulphurata, gr. ⅙ every hour.

April 28. Worse. Oil of ergot locally. Arsenic internally instead of calx.

April 30. Much better.

May 3. Fresh outbreak.

May 7. Still bad. Stop oil of ergot and use boric-acid ointment.

June 9. Steadily improving.

Sept. 29. I was out of town during the summer. He is now as bad as ever.

*Summary.*—And now what lesson shall we draw from the foregoing notes, imperfect as they are?

1. *As to Aetiology.*—Nationality is unimportant. The fact that the greatest number of cases occurred in those of American birth is of no significance, as it is due purely to the accident of the place in which the cases occurred. Occupation seems more promising as an aetiological factor. All but four of the patients were engaged in occupations that compelled them to live in close rooms filled with dust. It has always seemed to me that the disease takes special hold upon tailors. Their mode of life is about as unphysiological as possible.

A poor general condition of health is a prominent aetiological factor. In about one third of the cases digestive disturbances (dyspepsia and constipation) were noted. Doubtless, if the notes were fuller, more cases of like kind would have been found.

Nasal catarrh is noted in four cases in which the upper lip was affected.

The disease may appear at any age after the beard has begun to grow, but is most frequent between the ages of twenty and forty, nineteen out of the twenty-two cases occurring between those ages.

2. *The Course of the Disease.*—It is exceedingly chronic and shows little tendency to get well of itself. It may last for fifteen years and more.

3. *Location.*—The upper lip alone or in combination with other regions is most often the seat of the disease—fourteen out of twenty-two cases. The whole beard is quite frequently involved—five times in twenty-two. The chin alone is rarely affected—only twice in twenty-two cases. The scalp may be invaded.

4. *Treatment.*—While I have marked only one case as cured, nearly every case shows marked improvement under treatment, and without doubt some of them were cured but failed to report themselves so as to have the final result entered on the notes. If a study of these cases teaches anything, it is that one must be prepared to tack about from one method of treatment to another in conducting a case to a happy ending. The best results were attained by means of antiparasitics, which would support the theory of the coccogenous origin of sycosis.

The first thing to be done is to open up the pustules and get rid of their contents. Epilation, soap frictions, and the use of the dermal curette all do this, and all proved beneficial—twelve cases out of fourteen.

After epilation or curetting, the chosen application should be made, whether as an ointment or oil.

*Salicylic acid* with Lassar's paste proved beneficial in four cases; as an oil, with castor-oil, it did well in one case and seemed to aggravate in another.

*Tar* did well in two cases.

*Mercury* was most valuable in the form of Bronson's ointment (hydrarg. ammon., ℥j; hydrarg. chlor. mitis, ℥ij; vaseline, ℥j; M.), and I would say that ever since I learned its virtues, while I had the honor of assisting Dr. Bronson for a number of years at the New York Polyclinic, I have greatly esteemed it, and do regard it as the most elegant form of mild mercurial ointment. The solution of corrosive sublimate was also useful.

*Sulphur* in ointment-form did well in three cases, but was of no benefit in another case.

*Boric acid* proved very beneficial in three cases, but did no good in another case. Where it benefited it showed its good effect promptly.

*Diachylon ointment* was beneficial in two cases, and of no benefit in three cases. It is rather remarkable that the only case marked as cured got well while using this ointment.

*Ichthyol* proved harmful in the only case in which I used it. It should have been given a longer trial, perhaps, but at the time I had used it in a number of cases of other diseases without benefit, and so did not feel encouraged to further experiment.

*Resorcin* in three-per-cent. strength was used in two cases without benefit.

The exhibition of *sulphide of calcium* by the mouth was of marked benefit in four cases in which there was a good deal of pustulation. The calcium was continued until either the disease was greatly aggravated as shown by the outbreak of many new pustules, or benefited as shown by a marked decrease of the pustulation.

From a study of these cases I would formulate the treatment of sycosis as follows:

In acute cases where there is much pustulation, epilate or curette and apply boric-acid ointment, or Lassar's paste with salicylic acid. Give one tenth of a grain of calcium sulphide in fresh tablet triturations every one or two hours. If an acute outbreak of pustules occurs under it, stop it until a subsidence of the eruption takes place, and then begin again.

In subacute cases where there is not so much pustulation, but more redness and the disease is more patchy, epilate or curette and use Bronson's ointment, or one of sulphur or tar or other mild stimulant. Or use soap frictions, followed by protective ointments.

In chronic cases epilate or curette, or apply a solution of caustic potash carefully to diseased parts. Locally, employ strong ointments or solutions of tar, provided caustic potash has not been used. If caustic potash has been used, then apply a simple soothing dressing. The use of tar in alco-

hol, as proposed by Pick, of Prague, has of late given brilliant results in my hands in some cases of chronic eczema, and in the last few days has greatly benefited one of the cases here reported, one which had shown itself to be very obstinate. Soap frictions are also valuable at this time. As chronic and subacute cases may take on acute forms under stimulating treatment, we must be prepared at any moment to apply more soothing methods of cure according to indication.

For the best effect from our local treatment we must insist upon our remedies being kept constantly applied during day and night. To the same end the patient is to be advised to shave himself about twice a week. This is not absolutely necessary, but facilitates the action of our applications upon the diseased skin. If a rhinitis be present, appropriate remedies must be used for that.

While treating the skin affection we must not forget the man whom the skin clothes. We must address ourselves to the task of regulating the diet and general hygiene of the patient, and give medicine, if needs must, upon the same principles as we would if the patient came to us not for his sycoisis, but on account of his poor general condition.

5. The *prognosis* is always doubtful as to rapid cure. The disease is prone to relapse when apparently well. A cure can be effected only by persistent effort both by the physician and patient.

14 EAST THIRTY-FIRST STREET.

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## A RÉSUMÉ OF THE VIEWS OF DR. OBERLÄNDER ON THE PATHOLOGY AND THERAPEUTICS OF CHRONIC GONORRHŒA.\*

By J. A. FORDYCE, M. D.

**D**URING the past year a number of articles on the pathology and treatment of chronic gonorrhœa, by Dr. Oberländer and Professor Neelson, of Dresden, Germany, have appeared in the "Vierteljahresschrift für Dermatologie und Syphilis." In the spring of the present year the same articles have appeared in book-form.

The facts therein recorded are the result of endoscopic studies on the male urethra made during the past ten years, confirmed in part by microscopic investigations on the cadaver by Professor Neelson. The author reproaches the present methods employed in the treatment of chronic urethritis with the fact that they take little or no cognizance of the pathological changes which the disease has produced. Until the present time

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\* Read before the Association of Genito-urinary Surgeons at the Congress of American Physicians and Surgeons at Washington, 1888.

one has scarcely been familiar with the appearance of the diseased surface, much less with the manner in which the chronic changes are produced or how they heal. Oberländer has improved and arranged for more convenient use the apparatus invented about fifteen years ago by Dr. Nitze. He claims for his method the advantage over others in that the light is not reflected from without into the tube, but is introduced directly in front of the spot to be seen; by this means one obtains a direct illumination of the diseased or healthy mucous membrane. The light has a further advantage in that it can, by means of a rheostat, be made brighter or paler as one may desire.

By means of the endoscope one soon learns to recognize every, even the slightest, change in the mucous membrane, as changes in color, overfullness of the blood-vessels, infiltration of the mucous membrane, changes in the glands, the epithelium, the caliber of the urethra, the loss of elasticity of its walls, etc. It is evident that an accurate knowledge of the diseased condition is of great practical importance, and Oberländer, by means of his method, has solved an important problem, for, with all the endoscopes previously in use, one has scarcely been in position to diagnose a diseased condition of the urethra. Every observer saw something different, and no one saw methodically. In America an advance had been made in diagnosing chronic urethritis by means of the large-sized bulbous sounds and urethrometer of Professor Otis. Still, the direct observation of such localized spots of infiltration, and the manner in which they come about, was lacking. Every special physician in this branch of medicine will acknowledge that when one can see as well as feel the diseased tissue, a decided advance has been made. With the endoscope one will be enabled to form a correct diagnosis of chronic urethritis, to say when the disease is healed, and when a return is not to be looked for.

From an anatomico-pathological standpoint, the author differentiates the following forms of chronic urethritis:

First. *Affections of the mucous membrane without marked participation of the glandular elements.*

In such forms the infiltration is diffuse, and does not result in localized contractions. He subdivides this form into two varieties: (a) *Urethritis mucosa hypertrophica*; (b) *urethritis mucosa catarrhalis*.

The first variety is frequent, and comes usually eight to twelve weeks after infection. Viewed through the endoscope, the mucous membrane is swollen, has a dull, velvety look, the long folds of the mucous membrane are no longer seen, the affected portion bleeds freely on introducing the sound or wiping it with the cotton pledget.

The openings of the lacunæ are deeply imbedded in the swollen mucous membrane; here and there a little secretion can be seen issuing from them.

Such forms can heal without visible cicatrices. The second variety,

urethritis catarrhalis, is a rarer form, and is characterized as follows: The mucous membrane is less swollen and elevated than in the preceding variety; it has a bluish-red and spotted appearance, is more circumscribed, and small granulations can be seen covering spots the size of a pea, which spots readily bleed on being irritated. On other spots one can see slight erosions and epithelial proliferations. The openings of the glands are seldom seen. The lesions resemble those of chronic catarrh on other mucous membranes; they are a later stage of the preceding variety, and can also heal, leaving a normal mucous membrane.

The second chief division of chronic urethritis made by the author includes those forms in which the *glands of Littre* play the important rôle. In the normal state of the urethra one can only see the crypts of Morgagni, the openings of the glands of Littre being invisible. These glands are inflamed, hypertrophied, and such inflammation is generally combined with periglandular infiltration; besides, they are generally affected in groups, and lead to stricture formation. This form is named by the author *urethritis glandularis*, and is subdivided into four varieties: (a) *Urethritis glandularis circumscripta*, of which the endoscope gives the following picture: A circumscribed, almost round patch, half a centimetre to a centimetre in circumference, seen on various portions of the pendulous urethra. The mucous membrane covering these spots is without the long folds, projects somewhat into the cannula, and is paler and less shining than its surroundings. In the center, seldom at the periphery of the infiltration, one sees enlarged glandular openings, which, according to the stage of the disease, may be deep red or show the remains of former hæmorrhage into the glands. They may also be surrounded by fine circular cicatrices. These localized spots of infiltration never completely surround the urethra, and do not extend deeper than the thickness of the mucous membrane. When the above-described variety extends over a larger surface, one sees a large area without the folds in the length of the urethra, the openings of the enlarged glands scattered here and there, and occasionally superficial cicatrices with slight epithelial desquamation. A slight contraction of the urethra can result from this variety of urethritis. It seldom occurs earlier than six or eight months after infection, and heals with superficial cicatrices, which often disappear. The author calls the above variety (b) *urethritis glandularis superficialis* or *proliferans*.

The two varieties of glandular urethritis just described are limited to the mucous membrane, the submucous tissue being free from the infiltration. In the following two varieties the inflammation has extended deeper, and involved all the structures of the urethra; it ends with destruction of the invaded tissues in the cicatricial formation. That these severe forms originate in the glandular elements is proved by the fact that the extensive cicatrices are surrounded by a zone of hypertrophied glands, and

this zone becomes in time the seat of scar-tissue. A typical case of glandular urethritis, involving the deeper structures of the urethra, will appear as follows through the endoscope: The circumference of the affected area consists of a zone of deeply reddened and swollen mucous membrane, upon which are seen many hypertrophied glandular openings. Within this zone is a raised knobby or granulated mucosa of lighter color than the surrounding tissue in which the glandular openings are not seen.

In cases yet further advanced, meshes of cicatricial tissue of gray-red or mother-of-pearl color, according as they contain more or less connective tissue, are seen. The cicatrices are yet soft and present no decided obstacle to the introduction of the cannula. Its introduction, however, produces tears as deep as the infiltration extends, frequently to the cavernous body of the urethra. This quality of not yielding and tearing is characteristic of this variety of urethritis, being found in no other. The flow of blood caused by the tears immediately fills up the end of the cannula, obstructing the field of vision. Such forms of urethritis will not be seen within less time than a year after infection. In its later stages the granulations upon the mucous membrane disappear, leaving a number of cicatrices surrounded by swollen mucous membrane. The author has named this variety (*c*) *urethritis glandularis hypertrophica granulans*. The most intense form of glandular urethritis ends with the formation of more extensive cicatricial bundles, which project high above the level of the mucous membrane, preventing the passage of the cannula. As this variety produces stricture in the surgical sense of the word, the author proposes for it the name (*d*) *urethritis glandularis stringens*. Still another form of glandular affection is described by Oberländer, in which the ducts of the glands are obstructed, producing retention of their secretion. As a result of such retention, the mucous membrane is dry, dull in color, and covered with epithelial proliferations.

These epithelial masses have a yellowish-brown appearance and can be easily removed with the cotton pledget. According to the size and surrounding inflammation of the cysts, a marked diminution of the urethral caliber can result. This form appears from the author's observation to be the most frequent. He has called it *urethritis follicularis sicca*. Should this form have a long duration it will be attended with a high degree of cicatricial formation, causing marked obstruction of the urethra. In this severe form the author gives it the name *urethritis follicularis stringens*.

The anatomico-pathological investigations made by Professor Neelson confirm in great measure the clinical types proposed by Oberländer. Among three hundred and fifty male cadavers of middle age, thirteen were found with remains of urethral inflammation. The swelling of the mucous membrane, together with the epithelial proliferation, were, owing to cadaveric maceration, completely lost. On the contrary, the glandular



inflammation, and the partially or completely cicatrized herds, were distinctly recognizable. As a further result of his endoscopic observations, Oberländer finds that *papillomata* of the male urethra occur more frequently than has been supposed. He also finds on the vaginal mucous membrane and urethra of prostitutes changes corresponding to those in the male urethra.

Therapeutically, Oberländer follows closely the treatment advocated by Professor Otis. He claims for himself, however, to have founded the treatment on a scientific basis, besides controlling its results by means of direct observation. He disapproves of the cut advocated by Otis, claiming that, in order to obtain curative results by its use, one must accurately divide the affected portion, and that such a result is not always possible without direct observation. As a rule, he prefers dilatation to all forms of cutting operations, and has found that the tears produced by it always pass through the affected portions. In these regions the natural elasticity of the urethral walls is so far impaired or completely lost that they must give way to strong dilatation.

Oberländer treats every case of chronic gonorrhœa which refuses to heal by the ordinary methods by the use of instruments, generally his dilators, or, when the urethra will not admit them, by means of bougies. The dilators are those proposed by Dr. Otis modified somewhat by himself. They are always used with a covering of thin India-rubber. As soon as glandular infiltration has taken place one can scarcely hope to accomplish much good through the use of injections, medicated bougies, or ointments. The diagnosis having been made by the endoscope, and the absence of papillomata assured, the use of the dilator is indicated. A straight instrument is used for the pendulous urethra, a curved one for the deep urethra. Both endoscope and dilator are, as a rule, to be used after the application of a ten-per-cent. cocaine solution. In case the endoscopic cannula can be introduced, one can dilate to 25 F., the number corresponding to the size of the endoscopic tube. In case it can not, dilatation to 20 F. will be sufficient. Each succeeding time the instrument is used the blades can be separated one or two numbers over the preceding sitting. The dilator need not remain longer than five minutes in the canal. The rubber covering must always be lubricated with boro-glycerin, as all other substances render it hard and unfit for use. Before applying the rubber sheath it can be filled with Venetian talc by means of a powder-blower. After its use it is washed in a carbolic or boric-acid solution, and placed in ten-per-cent. salicylated cotton.

In the beginning of the treatment by dilatation of certain forms of chronic urethritis bleeding is usual. It occurs especially in those forms in which the urethra is stiff, brittle, and unyielding. After the dilatation has been repeated several times the bleeding ceases. As an aid to treat-

ment in such cases, a weak solution of nitrate of silver (1 to 2,000), injected through a soft-rubber or Ultzmann catheter by means of a two-ounce syringe, can be used to advantage. In the severe forms of urethral inflammation, when the treatment is followed by much hæmorrhage or pain, the dilatation can be repeated from every four to eight days, or a yet longer interval can pass before repeating it.

In *urethritis follicularis sicca* the hæmorrhage and pain are much less severe, so that the dilatation can be repeated more frequently.

In those forms in which the infiltration is of a light grade, and the natural elasticity of the urethra is retained, a much wider dilatation is necessary in order to obtain curative results. In such forms the blades of the dilators must be separated to from 30 to 40 F. The use of smaller numbers accomplishes nothing in such cases.

The weak solution of nitrate of silver injected in large quantities through the soft-rubber catheter can be used after the dilatation, both as an adjuvant to the treatment of the disease as well as for its healing effect on the tears produced by the instrument. Such dilatation, followed by the nitrate-of-silver injections, has been found by the author to be attended by more satisfactory results than the local treatment of the lesions through the endoscopic cannula. He has made use of the galvano-cantery and the sulphate of copper in substance, but has discarded them for the before-described treatment. The treatment must be continued until every trace of discharge has ceased; after this time, should filaments be seen in the urine, the dilatation should be continued.

In *five thousand cases* of chronic urethritis so treated by the author, he has neither had a death nor a severe case of urethral fever.

66 WEST FORTIETH STREET.

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## Society Transactions.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

#### 184TH REGULAR MEETING.

**Lupus Disseminatus.**—DR. ELLIOT presented a case of this affection which was noteworthy on account of its extent and the distribution of the lesions. Mrs. G., aged thirty, married, American. Father, uncle, and brother died of consumption. Five years ago there appeared on the face an itchy eruption, which remained for some months before it was cured. She has had comedones for years and has pressed them out with her nails. The comedones are still (August, 1888) present. The present affection is said to have appeared in July, 1888, and to have increased steadily until she applied for treatment in

August, 1888. At that time the patient was a slight, delicate, somewhat anæmic woman, who suffered from severe headaches, but whose general functions were in normal condition. The lesions were situated on both cheeks and on the chin. They were somewhat grouped, especially on the right cheek, but discrete. Some of the lesions were slightly elevated, and in size varied from a very small pin-head to a small pea. In color they were of a reddish-brown, having also a gelatinous transparency. There had also been a group of identical lesions on the left elbow, which had disappeared spontaneously. Involution of some of the spots on the face had also occurred, leaving superficial scars, and new ones had made their appearance. When first seen, a definite diagnosis was not made, but it was thought that they were probably stains from acne lesions. New spots appearing continually, without precedent acne pustules, demonstrated that the affection had nothing to do with acne. The diagnosis was not made until after microscopical examination of sections from a small lesion excised from the chin showed tissue characteristic of tuberculosis. High up in the cutis, just below the papillæ, small tubercles were found, formed by granulation tissue and containing giant cells, epithelioid cells, etc. Staining for the tubercle bacilli was not possible, because the lesion excised was so small that only a dozen sections were obtained. The remainder of the cutis showed no change of any importance, and the sebaceous glands were not affected. Dr. Elliot regarded the case as one of lupus disseminatus superficially situated.

In the discussion of this case, DR. ROBINSON said that, from the clinical appearances alone, he would not have made the diagnosis of lupus; he thought that the presence of the bacillus was needed to confirm the diagnosis.

DR. FOX said that from a clinical standpoint the case was very similar to a few other cases he had seen, which he had diagnosticated as colloid milium. In one patient he was for a time at a loss to know whether the case was one of acne or of syphilis. He thought at first that it was acne, but changed his mind when he found that the dermal curette dug out little balls of gelatinous matter, leaving a punched-out hole in the skin. He had another case like the one before us, but not so well marked. He would regard the case as a peculiar form of acne. The clinical appearances were certainly unlike lupus. He was so skeptical of the microscope as a means of diagnosis that, while he did not doubt Dr. Elliot's ability as a microscopist, he would like to have had the opinion of several as competent men upon it.

DR. ELLIOT, in closing the discussion, stated that, notwithstanding the bacillus had not been demonstrated in the lesion, yet he would consider it as lupus. The lesions offered not the slightest resistance to the entrance of the nitrate-of-silver stick, a feature belonging to lupus, and, besides, the histological anatomy of tuberculosis was so well known and easily recognized that he thought the features characterizing that form of granuloma being present, the diagnosis could be conclusively made even without the bacillus. He had seen the cases mentioned by Dr. Fox. The first one he had also considered as representing a colloid degeneration, presumably of a sebaceous or sweat gland. The second case he had thought similar, as also, at one time, the case presented to-night. He had, however, obtained a lesion from Dr. Fox's second case, and, though he had not decided what the disease really was, yet it had

nothing to do with a granuloma and was entirely different from the case—microscopically—that was seen to-night. The lesion from Dr. Fox's case showed no evidences of colloid degeneration, but in portions looked sarcomatous, in others fibromatous. He had, however, come to no definite conclusion as to its nature.

**Multiple Sarcoma.**—DR. SHERWELL then presented a case of this disease, this being the same case that was before the society last spring, and reported in the April number of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES. At that time there was only a single large tumor upon the left thigh. This was excised in April and the diagnosis confirmed by the microscopical examinations of Dr. Robinson, Dr. Elliot, Dr. Bates, and others. Within a month after operation other tumors began to appear on other parts, until dozens of them were scattered over the body. Some of these were removed by the knife, some curetted off, but what was most remarkable was that a number of them had disappeared under the use of arsenic in large doses, the patient having taken as much as one hundred and eight drops a day in divided doses of a mixture composed of Fowler's solution, one ounce, and Donovan's solution, two drachms.

DR. ELLIOT was very much interested in the remarkable result of the treatment in the case.

DR. ROBINSON, while admiring the result of the treatment, was sorry that Donovan's solution had been added, as that interfered with the scientific observation of the effect of the arsenic.

DR. FOX said that the result of treatment was certainly brilliant, but he had seen arsenic improve these cases before, though only for a time. Ultimately death ensued.

DR. BRONSON wished to speak in connection with this patient of his case of melanotic sarcoma. It did not show the slightest improvement under the use of arsenic. He had given him the drug up to thirty drops a day by the mouth. More than this he could not stand, arsenical-poison symptoms arising.

DR. SHERWELL would only say that he gave Donovan's solution for the benefit of his patient, not for the cause of science. He believed that mercury exerted an abortive effect on the new growth, and gave it for that reason, quite without any idea of there being any specific element in the case. To the arsenic he would ascribe the improvement in the case. It certainly was not due to any changes in the diet, for in that there had been no change.

**Popular Eczema, or Lichen Simplex.**—DR. ROBINSON presented a case of this affection which was remarkable on account of the uniformity of the lesions both in color and size. It was located chiefly on the extremities, but there were some lesions also on the trunk. The child was eight years old and was brought to the Deutsche Poliklinik with a mild attack of rheumatic endocarditis. Some six days afterward he had an outbreak of measles, and that was followed in about two weeks by the present eruption.

DR. SHERWELL could not agree in the diagnosis of eczema.

DR. ROBINSON said that he would not insist upon the name eczema in this case. He presented it on account of the uniformity of the popular lesions that had existed for fifteen days without the formation of vesicles, the slight

color of the lesions on the forehead, and the presence of a number of perfectly flat, polygonal papules with depressed centers, looking like those of lichen planus.

DR. FOX remarked that he had given up the old term lichen simplex and called all such cases papular eczema, as precisely similar lesions were to be found at the edges of patches of eczema. It was usual to find patches of oozing eczema in the flexures of the joints in papular eczema, and probably they would develop later in this case. Papules resembling those of lichen planus in shape were not infrequently found, but it was rare to find them with the central depression, as in this case.

**Psoriasis versus Eczema Seborrhoicum.**—DR. ALLEN showed a case of this disease. The patient was a woman, aged forty-one. The eruption first appeared on the right shin fourteen years ago. It was very itchy. She has now an eruption over the whole body, and this is the third outbreak of the disease in this form. It has always been very pruriginous. She is the only one of ten children who has ever had any skin disease. When first seen some five weeks ago she had only a patch of disease in one popliteal space and large eczema-like patches upon the legs and crusts upon the scalp, and I asked her to come here to-night, intending to present her as a case of seborrhœal eczema. The psoriatic patches upon the elbows and trunk have developed since then.

DR. KLOTZ would call the case one of psoriasis.

DR. FOX thought that the patches on the breasts and elbows were those of psoriasis. He was inclined to regard eczema seborrhoicum as a connecting link between eczema and psoriasis. There are certain forms of hybrid diseases. It was to him remarkable that since his attention had been called to eczema seborrhoicum so many cases of marginate eczema had appeared.

DR. ELLIOT would regard the case as Dr. Fox did: The patches on elbows and body, and some on legs, as psoriasis; the one in the popliteal spaces as eczema seborrhoicum. He could not, however, agree with Dr. Fox that there could be a disease which was on the border-line between psoriasis and eczema seborrhoicum, and which represented a transition from one to the other. The two could exist together, and the symptoms of each be present clinically, but pathologically the eczema was a catarrhal affection, situated in the cutis, affecting especially the so-called sweat-glands, while the psoriasis was primarily and almost entirely a disease of the epidermis. He could not understand a disease which, partaking of the pathological character of both, yet was neither the one nor the other, but something different and distinct.

**A Case for Diagnosis.**—DR. ELLIOT presented a male, aged twenty-three, an electrician. The patient came to the New York Skin and Cancer Hospital, Dr. Bulkley's service. He stated that his mother, who is dead, suffered always from severe headaches. He is the eldest child. He can give no history of his general health previous to the age of ten. At that time he had a series of ulcerations on the legs and thighs, which ran a course of several months and healed, leaving flat, superficial white scars. A period of quiescence followed. At the age of nineteen, lesions appeared upon the bearded portion of the face, and the process was then diagnosed as a sycosis, and has been continually treated as such. When first seen by me I found upon the extensor surfaces of the legs and thighs the scars already mentioned. They

were single and grouped, thin, white, and the edges of some still showed traces of pigmentation. The edges were scalloped more or less. On the right buttock the scars were arranged in a semicircular manner, and on the left arm was a pigmented recent scar. The new process was found to be present on both sides of the face, and extended from the ears to the angle of the jaw on the left side and to about the middle of the ramus on the right side. It was limited to the beard except on the right side, where it extended beyond its limits upon the cheeks, the edge here being scalloped. On the right side, at the inferior extremity of the patch, was a group of superficial ulcers of various sizes, covered with crusts, and at the upper end near the ear was a single ulcer. The space intervening was constituted by a uniform scar, devoid of hair, which was thin over most of its extent, but in places showed a keloidal hypertrophic condition. On the left side, at the lower extremity of the patch, there was again a group of ulcers, while the space to the ear was formed by a scar similar to the one on the right side. The beard, the neck, and the moustache were unaffected. The hairs were still *in situ* where the ulcerations were, and showed no trace of disease. Dr. Bulkley had diagnosed the case sycosis. Dr. Elliot thought it was a case of mild hereditary syphilis, or one contracted in infancy. It was presented, consequently, for a diagnosis.

DR. FOX would diagnose the case as one of sycosis upon the face, as he had seen cases leaving similar scars. Upon the trunk the scars might be those of syphilis, but they possessed no positive characteristics.

DR. CUTLER would diagnose the disease on the face as sycosis.

DR. KLOTZ could not imagine that sycosis could produce such scars as were seen in this case. If they were seen on any other part of the body they would be pronounced syphilitic without hesitation. At the same time it was odd that so late a manifestation of syphilis should occur upon both sides of the face, but this symmetrical location did not speak absolutely against syphilis.

DR. ALLEN would regard the case as one of sycosis on the face, but thought the patient syphilitic and the process on the face modified by the syphilis.

DR. SHERWELL would ask if it might not be scrofula. The disease appeared rather late for hereditary syphilis. The cicatrices did not seem to him like those of syphilis. He would prefer to regard the case as one of sycosis in a scrofulous subject, in whom the disease is often very rebellious.

DR. BRONSON thought that the case was a doubtful one. It might be sycosis. If syphilis, it is strange that it should occupy the region of the bearded portion of the face alone. Moreover, it was not serpiginous, and the scars were too striated. On the other hand, sycosis simplex could not have produced that amount of cicatrization. It was possible that a parasitic sycosis might have been present at some time.

TO DR. KEYES the scars on the thigh appeared characteristic of syphilis. The scars of scrofuloderma are adherent, while those of syphilis are not so, excepting over bones. Those of rupia, however, do adhere. If the disease on the face be syphilis, it is remarkable that it should confine itself to the hairy portions.

DR. ELLIOT, in summing up, stated that he could not understand a sycosis in which the hairs were not affected. Moreover, the disease having existed for four years, he would expect that the subcutaneous connective tissue would have been affected and probably diffuse phlegmonous processes have occurred, and at any rate he could not see why the disease had not extended in that time at least to the chin and neck. Scarring occurred in sycosis, but it was not uniformly diffused. He did not think grouped ulcers, but follicular losses of tissue, would occur in sycosis. That the cicatrices were not typical of syphilis was conceded. This might be owing to the many nostrums applied by the patient. He could not accept the diagnosis of scrofuloderma, as in such a case the scars would be deep and puckered, occurring over the site of lymphatic glands which had ulcerated and broken down, or arising from the breaking down of *gommes tuberculeux*. There would also be enlarged tubercular glands and other symptoms belonging to the process. In favor of syphilis were the character of the scars on the lower extremities, and the presence of grouped ulcerations, which would seem, from the condition of things on the right cheek, to have started from one point and progressed both upward and downward. It was somewhat difficult to regard the process as an example of late hereditary syphilis, owing to the absence of those major symptoms characterizing that disease. Still he considered the process as syphilis, though its origin was not clear.

**Urticaria with Erythematous Syphilide.**—DR. ALLEN then presented a case of this disease. The patient was a man twenty years of age. Eight weeks ago he had a sore of doubtful character. Three days ago he came again with a roseola, accompanying which was an urticaria. He complained greatly of the itching, which he said had preceded the appearance of any eruption for several days, and during the preceding week he had lived principally upon "sea-food." Characteristic wheals were present. Scratches with the nails are still followed by the appearance of long wheals. His only treatment has been rhubarb and soda, under which the urticarial features of the disease have disappeared, leaving the macular syphilide. At the first visit the whole eruption might have been regarded as one of urticaria in the absence of history.

**Sycosis, a Clinical Study.**—DR. JACKSON then read a paper on this subject. This paper appears in the present number of this JOURNAL. In the discussion of the paper, Dr. Sherwell said that he had found linseed oil to be one of the best remedies when used freely for a time, then washed off with tar soap, and followed by oleate of mercury, oil of cade, or other oil.

DR. BRONSON believed especially in epilation and the use of the curette, riding roughly over the surface, and truncating the pustules and tearing out the hairs.

DR. FOX would indorse mechanical treatment and speak especially of epilation. A recent author mentioned a long list of internal remedies in this disease, but condemned epilation. Epilation was, nevertheless, by far the most valuable remedy we had. It was best to epilate from the start except where there were a great many pustules, and then it was better to curette. After epilation the inflammation subsides and we have only the redness, which needs slight stimulating treatment, as with tar oil. The epilation

should be continued where necessary and the general condition of the patient looked after.

DR. ELLIOT had attained the best results by a strict antiseptic treatment and improving the general condition of the patient. The bichloride of mercury,  $\frac{1}{2}$  to  $1\frac{1}{2}$  per cent. in alcohol and ether, resorcin in 10 to 30 per cent. strength, and a 10 per cent. ichthyol soap or ointment, had proved themselves rapidly curative if kept constantly applied. He had by these means cured cases without epilation.

DR. KLOTZ thought that some of the cases confined to the upper lip were merely eczemas, originating as moist eczemas of the nose, and becoming pustular by subsequent infection. He had achieved his best results by the use of an ointment composed of beta naphthol, one part, sulphur, three parts, and ointment, thirty parts, which he preferred to the strong naphthol paste of Lassar. Sometimes he had to alternate with boric acid. Shaving should also be practiced.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**The Destruction of Hairs by Electrolysis.**—At a meeting of the Medical Society of the Hospitals of Paris on August 10, 1888, I made a note of correction in a communication relating to the history of the destruction of hairs by electrolysis. I called attention to the fact that in my first communication to the society on this subject in 1886 I had given the honor of first advancing the idea of destroying by electrolysis the hairs of trichiasis to Dr. Michel, of St. Louis, in the United States, but I made the mistake, due to being led into error by a memoir of Dr. Hardaway, of attributing the date of these first attempts to the year 1879.

Therefore Professor Léon Le Fort, of Paris, believed himself authorized to claim for himself the priority of this discovery, and informed me that in the eighth edition of his "Manual of Operative Medicine," edited in 1877, he had already proposed the destruction of deviated eyelashes by the electrolytic current. In my second communication to the society on the destruction of hairs, and also in my American correspondence, I claimed the priority for the French surgeon. In the month of July of this year I received a letter from Dr. Hardaway, informing me that the exact date of the publications of Dr. Michel was not 1879, but in October, 1875. I immediately transmitted this discovery to Professor Léon Le Fort, who answered me in the following words: "I brought out the first volume of the eighth edition of my "Manual of Operative Medicine" in 1874. I began work at once upon the second volume. It is in the first part of this second volume that I speak of trichiasis. I must have prepared this article early in 1875. But that makes little difference; the volume did not appear till 1877; the publication of Dr. Michel was in



1875, and he has all the incontestable rights of priority." It rests, then, a well-established fact at the present time that if Professor Léon Le Fort had the idea of employing electrolysis for the destruction of deviated hairs, without having had knowledge of previous work in this field, still the first publications on this subject are due to Dr. Michel, of St. Louis, U. S. A.

My communication to the society correcting this error was made on the 10th of August, 1888, and I had hoped in my next letter to have the pleasure myself of correcting in the JOURNAL this little error, which was entirely involuntary on my part, as is plainly seen, and for which the first responsibility should be attributed to Dr. Hardaway. I was therefore disagreeably surprised to find in the September number of the JOURNAL a letter from Dr. Hardaway containing the claim of priority for Dr. Michel. However, this little incident should be regarded as settling the question for all time to come.

**Alopecia Areata.**—Professor Leloir, of Lille, read, on the 26th of June last, at the Academy of Medicine of Paris, an important work on the subject of alopecia. Out of 142 cases which he has observed he has been enabled to carry out a satisfactory investigation in 92 instances. He has divided these 92 cases into three grand classes from an ætiologic and pathogenetic point of view. In the first class he has placed the observations in which he found no sign of contamination of the subject or of his environment, and where there existed, on the other hand, sufficiently characteristic nervous phenomena. To these he has given the name of *trophoneurotic alopecias*. He has found in a number of these cases the primary cause of the nervous troubles to be overcrowding in dwellings and particularly the overcrowding of schools, decided moral emotions, prolonged grief, and traumatism of the head. He has frequently observed the co-existence of these losses of hair with a syphilis of several years' duration, and in one case the affection of the scalp preceded an attack of cerebral syphilis; out of the two histological examinations of the nerves which he was able to make in this first class of cases he found them once in perfect condition, and once presenting all the signs of degenerative atrophic neuritis in process of evolution. In the second class he places those observations in which he has not been able to find, as an explanation of the disease, either nervous affections or contagion. In the third class he places the cases which, after a most searching inquiry, he has been led to consider the alopecia as contagious. He has never been able to discover any parasite either in the hair or in the skin, and has never succeeded in giving alopecia to animals. In conclusion, he admits the opinion of Lailler, Vidal, and Besnier, that there exist both contagious alopecias and alopecias presenting the same features, but which ought to be attributed to troubles of innervation. There are no clinical characteristics which enable us to distinguish between these two orders of affection. He maintains that an investigation should be made before a child with an alopecia is admitted to the schools. If it be proved that it is a case of contagious alopecia, radical measures and isolation should be carried out. If, on the contrary, we have to deal with a trophoneurotic alopecia, it may be received in the school; but in cases of doubt decided prophylactic measures and supervision are advisable.

The communication of Dr. E. Besnier on the subject of alopecia areata which he made to the Academy of Medicine, July 31, 1888, constitutes a most

complete and carefully prepared monograph. Those who desire to know the exact state of science on this question at the present time should procure this work of 48 octavo pages. It may be reviewed from a scientific standpoint in the following manner: All the parasites which have hitherto been described in alopecia areata—vegetable growths, spores, and microbes, whether observed within the hairs, upon the surface of the scalp, within the epidermis, or in the derma itself—have no real pathological value. None of them can be considered as the true productive agent of the affection; on the other hand, the hair from a patch of alopecia presents all the features of an atrophied hair, one in a state of atrepsy, or cadaveric. It appears to have suffered a mortification from nervous action. It shows none of the characteristics of a hair attacked by a parasite. It would seem, then, that, whatever may be the cause of alopecia, this cause acts only through the intervention of the nervous system. On the other hand, if it be at times possible to make out a peculiar neurotic condition in those suffering from alopecia areata, it ought to be a constant condition, and most frequently we can not find any physical or moral shock of real worth as a starting-point of the affection. These shocks are produced almost always without producing the slightest alopecia areata, and it is the same with mental and nervous diseases. If certain alopecias proceed from a pure trophoneurotic origin, and if the eliminative process of the hair is a neurotic one, this does not imply in any way that the common form is a pure trophoneurosis, and does not in any way exclude the possibility or the probability of the action of an extrinsic causative agent of which we are ignorant, but of which the idea is inseparable from the fact of the transmissibility which belongs to ordinary alopecia areata.

Alopecia is indeed transmissible in certain cases from man to man, and many examples of it have been published in France. Dr. Besnier relates new instances of transmission. Furthermore, this disease acts from an aetiological standpoint like a tinea. The variations of the disease, according to time and place, the foci which are formed at the same place or in collections of the same order, the facility with which these foci are destroyed by measures of prophylaxis applicable to all tinea, the certitude of its transmissibility under suitable conditions, and finally the inequality of its geographical distribution, all concur in showing that the doctrine of pure trophoneurosis is only applicable to particular alopecias and not to ordinary alopecia areata (E. Besnier). Beyond this there is nothing fixed or known in the transmissibility of alopecia. At times it is reproduced with the greatest rapidity and with the most deplorable facility; at times, on the contrary, the most intimate relations can exist between one affected and a healthy person, without even the most elementary precautions having been taken, and no contamination takes place. Cases which do not create foci of contagion about them are those in which the head is well covered with some oily material, is regularly washed every day, and in which some appropriate treatment is being carried out.

Although the contagion is at times direct, it seems more often to be indirect. It is especially favored by articles of toilet, combs and brushes, head-dressings, pillows, bolsters, the various articles of furniture upon which the head is rested, etc. Dr. Besnier cites some clinical observations which make

it appear, but which do not prove, that alopecia areata may at times originate from the lower animals. The opinion generally held on the subject of the time during which the disease is the most transmissible, is that the contagious power disappears for some time before the absolute cure of the case. Dr. Besnier can not accept this opinion. He has seen the husband contract the disease from the wife, the father from the daughter, etc., at a period in which the disease seemed to be at an end. But this must be more especially because at this period the care exercised is less strict. The author finds no difficulty in recognizing this condition.

It is in adhering to these facts as to pathology that the commission of the Academy of Medicine of Paris, of which Dr. Besnier was chairman, has prepared the following rules of instruction regarding measures to be taken with those attacked with alopecia areata:

*General Measures of Prophylaxis.*—No subject of the disease can claim his admission or his retention as a right in a public institution. Such admission or retention are subordinate to the results of an open investigation by the physicians of the institution.

We should take all the measures necessary for the protection of healthy subjects against mediate or immediate contact with regions attacked with alopecia areata.

The heads of these patients should be kept covered, or at least the diseased surfaces should be wholly hidden, with some head-dressing, partial or complete wigs, adhesive plasters, collodia, or traumaticines.

An energetic treatment should be instituted at once. The hair should be cut short over the whole head. The beard should be shaved or cut short with scissors. Each morning the diseased parts should be washed with hot water and soap, without reference to the other means employed to bring about a cure.

Precautions must be continued for a long time after a cure seems assured, for fear it may not be complete and that recurrences may take place. Exchange of hats, caps, etc., must be prevented in all possible ways, both in public institutions and in the family. The use in common of articles of toilet and bedding must be prevented. Any object which has been in contact with the head of a patient with alopecia areata must be disinfected, if not destroyed.

*Special Measures of Prophylaxis.*—Every subject of the disease who demands admission into a public institution or who is already there must be made the object of a special and thorough medical investigation, which must determine, from the duration and course of the affection, from the state of the scalp, and the probable origin of the disease, whether the patient can be admitted or retained in the midst of his comrades. For asylums and schools for young children, non-admission, exclusion, or efficient isolation must be the rule, for the interruption to the studies is of no serious consequence at this age, and it is useless to rely upon the little patients to carry out prophylactic measures. In the primary schools and in all the day-schools it will be possible to admit or to retain cases, provided they be separated during the class hours and isolated during recreation time, and that they keep the head covered and are subjected to proper treatment. For boarding-schools, high-schools,

special schools, etc., non-admission or temporary exclusion will only be called for in rare instances and in particularly intense cases, for it is easy to keep these cases under supervision, and they can be relied upon to carry out vigorous treatment and observe prophylactic measures.

For the army, it is only necessary to continue with the strict rules now in force, which have for their object : 1. The isolation of the soldiers, either in the hospital, the infirmary, or in a special room. 2. The application of a series of measures comprising the particular hygiene of the patient and of those around him ; means similar to those which we have just enumerated. Exchange of hats or caps is forbidden. The hair must be cut close and the head washed with soap. Patent hair-clippers are to be suppressed ; scissors must be passed through a flame after each hair-cutting, etc. Finally, in all cases where subjects of alopecia are retained and tolerated in places where many are collected together, and thus become plainly the originators of new cases, this tolerance must cease at once, and all those affected must be sent away.

**Destructive Folliculitis of Hairy Regions**—On the 10th of August, 1888, Dr. Quinquand made a very interesting communication to the Society of the Hospitals of Paris on a special form of folliculitis which is followed by an incurable alopecia which simulates alopecia areata. The usual site of the affection is the scalp, but it may affect the beard, the pubis, and the axillary region. The bald patches are irregular, nearly smooth, polished, the skin is decolorized, white, as though atrophied, and may present in some points a slight redness. The patch is depressed and has a pseudo-cicatricial appearance. The morbid process is essentially constituted by follicular lesions of various aspects which exist at the periphery of the plaques of alopecia, themselves consecutive to the evolution of these lesions. The lesions consist in purulent points like miliary abscesses of the size of the head of a pin, or still smaller. They are punctiform, and from the center emerges a hair, which soon falls spontaneously, or else there are simply little crusts resting on a red base, which is slightly moist, or there may be a red follicular elevation. There are neither tubercles nor favus cups nor seborrheal alterations.

The evolution of the disease is altogether peculiar. An alopecia is first noticed, but in studying it we see that it begins in isolated points situated around the hair-follicles. A red elevation is noted, and often, though not always, the folliculitis is suppurative ; crops of small pustules are produced at the base of the hairs, but the number of these purulent points is relatively small ; they may be counted, and are isolated from each other. We have then an acute epilating folliculitis, proceeding by successive crops and lasting for a very long time. The author gives the complete histology of the affection. He has found a special micrococcus under the form of a monococcus, of a diplococcus, or in a series of four, having the size of from three tenths to four tenths of a micromillimetre. The microbe exists in the hair-follicle and in the blood of the inflamed region. It can be cultivated, and if frictions are made with the culture fluid over hairy parts, it will produce lesions of the follicles and loss of hair in the rat, the rabbit, and in man.

Treatment consists : 1. In cleansing with care the hairy part with soap and water. 2. In applying every ten days to the diseased region and to the

neighboring parts tincture of iodine. 3. In applying the following lotion each morning :

R Biniiodide of mercury.....	0.15	gramme;
Bichloride of mercury .....	1	"
Alcohol at 90°.....	60	grammes;
Water.....	500	" M.

After about a month of this treatment, the folliculitis is no longer produced, but an irremediable alopecia persists.

**Folliculitis and Perifolliculitis Decalvans.**—On the 12th of October, 1888, I made a communication to the Medical Society of the Hospitals upon a small category of conditions which come within the preceding morbid type described by Dr. Quinquand. These cases are characterized: 1. By a follicular and perifollicular inflammatory process. 2. By a complete destruction of the hair papilla, giving rise to a definite alopecia. 3. By the formation of a tissue having more or less the appearance of cicatricial tissue. 4. By a certain tendency which the lesions have to systematize and group themselves. I have not taken account in this study of well-known conditions, such as parasitic sycosis or trichophytosis favus, and that curious affection which we know in France under the name of atrophic and ulcerating acne, and which they call in Germany *acne varioliforme*. From a clinical and objective point of view, we have classified the conditions of which we speak into three principal groups: A. The first variety, which I have already mentioned in my letter of February, 1885, is extremely rare. It simulates alopecia areata, with which it is probable that it has been confounded until now, and from which we get the name *pseudo-pelade*, under which I propose to designate it. The follicular and perifollicular inflammatory process is here slight, for it is not characterized by much tumefaction, and the scalp has only a light rosy tint surrounding the affected hair. This hair soon falls spontaneously, and the inflammatory process is calmed; but it has produced a complete atrophy of the hair papilla, and only a white, smooth, ivory-like portion of scalp is seen, which seems to be atrophied, and upon which there is no vestige of hair or lanugo. The affection reaches the neighboring hairs without observing an excentric march of much regularity. On the contrary, it sends out very irregularly formed prolongations into the healthy regions. B. The second variety corresponds to the disease of which Dr. Quinquand has given the description (see above). The inflammatory lesions are here characterized by a suppurative folliculitis, but the spots remain isolated, discrete, and distinct from each other. There is produced a sort of smooth, white, depressed cicatrix, at which point the skin of the scalp appears atrophied and thinned. C. The third variety is observed especially in the beard, and here the inflammatory lesions are much more marked than in the preceding varieties. They are characterized by large follicular and perifollicular pustules, by redness and thickening of the skin, by the production of crusts and scales, and there is here confluence of the adjacent lesions. In a word, the disease resembles a sycosis of the non-parasitic variety. It differs from it by the constant tendency to extend in a regular centrifugal manner, and there is a complete atrophy of the pilo-sebaceous system. All the hairs of the affected part are, indeed, radically destroyed. A central cicatrix persists after the evolution of

the process, which is more or less hard, thickened, and keloid-like to the feel and sight. It varies in color from a more or less dark red to a dull white. This latter tint is ordinarily the definite one. It may be smooth and even, but more frequently it presents on its surface little fibrous tracts more or less prominent and irregular. All traces of hairs, lanugo, and follicles are lost. The disease spreads constantly from the borders, and gives an altogether characteristic appearance of a central absolutely bare cicatrix surrounded by a zone of activity of a red inflamed sycosiform appearance. There are no small foci scattered here and there, but one or two large ones (rarely more) limited to the hairy regions of the face, and quite often symmetrical. We do not as yet know anything definite and precise as to the nature and aetiology of this dermatosis, to which I have thought it proper to give the name *lupoid sycosis*—a designation which seemed to me to have the advantage of recalling the two affections which it most closely resembles from a symptomatic aspect—sycosis and lupus. It is very rebellious to treatment, but, when an energetic course is pursued, it finally is arrested in its extensive march, and ends in recovery. The treatment which has seemed to me to succeed the best consists in washing with a solution of corrosive sublimate of 1 to 1,000 or 1 to 500 strength, followed by applications of red plaster (minium, cinnabar, and diachylon), or Vigo plaster, actual cautery, and, above all, quadrilateral linear scarifications quite deeply made to reach the limits of the disease.

We might, it seems to me, associate within limits, to the preceding conditions, the affection which is known in France under the name of keloid acne or keloidal sycosis of the nape of the neck, and which has been termed elsewhere dermatitis papillaris capillitii.

**Treatment of Tinea Tonsurans by Tincture of Siegesbeckia.**—Dr. Hallopeau, who, since the retirement of Dr. Lailler, has had charge of the service of the tinea at the St. Louis Hospital, has tried the procedure advanced by Dr. J. Hutchinson in the "British Medical Journal" of June, 1887, who claims to have cured, after quite a long time, two cases of tinea tonsurans by frictions morning and evening with a mixture of equal parts of tincture of siegesbeckia and glycerin. He has found with regret that this method was completely inefficacious. At the present time he employs in his service with some success the treatment formulated by Dr. Vidal, which consists in applications morning and evening to the diseased regions, which have been previously shaven, first of a layer of vaseline, which is covered with an impermeable dressing. Dr. Lailler has modified this procedure a little in adding to the vaseline one per cent. of iodine. The improvement then takes place quite rapidly, although complete cure requires months. In the discussion which followed the communication of Dr. Hallopeau to the therapeutic society, I should state that several members recommended the use of oleates in treating the tinea. These oleates have, however, been used long ago in America.

D. L. BROCCQ.

PARIS.

## Selections.

### Erysipelas—Erysipeloid.

FERREIRE employed in a case of erysipelas of the leg in a child of two years and a half 8 milligrammes of resorcin in 60 grammes of traumaticine, with good results, and recommends it as a dressing to secure even pressure, occlusion, and an anti-parasitic action.

Ducrey treats erysipelas with hypodermic injections of corrosive sublimate, 1 to 1,000. The injections are made a few millimetres from the edge of the patch and about 3 centimetres apart, and repeated in 12 hours.

A committee was appointed some time since to inquire into the prevalence of erysipelas in the wards of the Vienna General Hospital. It was found that in 1882-'83 there were 290 cases and 25 deaths, and in 1883-'84, 241 cases and 30 deaths. Two hundred and eight were afflicted with internal diseases. Of these, genuine erysipelas of the face gave 43; secondary or consecutive erysipelas of the face, 56; of other parts, 109. The average death-rate was 10·3 per cent., but from genuine erysipelas alone was only 0·3 to 0·5 per cent.

As a result of the investigation, it was recommended that all erysipelas cases be strictly isolated.

Schwimmer has had occasion to note the effect of intercurrent erysipelas upon various lesions of the skin. While general syphilitic infection of the system remains uninfluenced by severe attacks of erysipelas, the local syphilitic products heal very quickly. Localized lupus also remains uninfluenced in complicating outbreaks of erysipelas. In a case of severe cicatricial keloid following a burn, resorption and cure of the keloid took place after an attack of erysipelas. In a case of chronic double epididymitis and orchitis, cure took place after an erysipelas of ten days' duration.

Erysipeloid is, according to Rosenbach, a disease due to wound infection with foul animal matter. Thus butchers, cooks, fishermen, tanners, etc., are those mostly affected, and the disease occurs almost always upon the hands. The affection, which is very similar to erysipelas, spreads slowly over the hand, and runs its course spontaneously in from one to three weeks. Cocci similar to Cohn's "*cladotrix dichotoma*" have been found and cultivated.—*Vierteljahr. für Derm. und Syphilis*, No. 2, 1888.

### Extra-genital Syphilitic Infections.

In an article in the "*Monatshefte für praktische Dermatologie*," No. 7, 1888, Dr. O. Petersen has collected all the available statistics showing the relative frequency of extra-genital chancre. In Mauriac's hand-book, 1,773 cases of syphilis in men are collated from various authors, in which were only 76 cases (4·3 per cent.) of indurated chancre; these were situated as follows: Lips, 36; anus, 12; abdomen, 9; tongue, 8; toes, 3; fingers, 2; eyelids, 2; gums, cheek, ala nasi, and buttocks, each 1. In Dr. Petersen's venereal service at the Alexander Hospital during the seven years from 1878 to

1884 there were 1,208 cases of syphilis in men. Among these there were 23 cases (1·9 per cent.) of extra-genital chancre, distributed as follows: Lips, 11; anus, 9; abdomen, 2; cheek, 1. Professor A. S. Gray, of Kazan, puts the percentage of extra-genital chancres at 8·9, but he does not give the number of cases from which this percentage is reckoned. Bogolyuboff, in his report of the Kroustadt Marine Hospital, gives 4 cases of extra-genital chancre (lips, 2; eyelids and tonsil, each 1) in 753 cases of syphilis, or one half per cent. Grödinger reports of 231 cases of syphilis in the Riga Hospital, 3 of extra-genital chancre (lips, 2; fingers, 1), or 1·3 per cent.

In the case of women the figures are somewhat different. Mauriac has collected the statistics of 291 cases in which the seat of the chancre was given, and finds it on other parts than the genitals in 19 cases (6·5 per cent.), distributed as follows: Lips, 9; anus, 5; nipples, 2; tonsils, buttocks, and gums, each 1. Kobylin reports 6 cases of hard chancre of the nipples in 77 cases of syphilis in women presented for treatment in the Kalinkin Hospital during the year 1880, and Sperk states that extra-genital infection occurs in 24·3 per cent. of the cases of syphilis in women, occurring in the same hospital. Plinatus met with 13 cases of syphilis contracted by women who nursed the infants in the Foundling Asylum of the Kreuzeserhöhung Sisterhood during the years 1870-73.

Of indurated chancres of the tonsils, Dr. Petersen has collected the reports of 42 cases. In 30 cases the particular tonsil is mentioned, and of these the chancre was situated on the right tonsil in 18 cases, and on the left in 12. It occurred rather more frequently in men than in women, and usually in children from three to fourteen years of age, though one case was reported in a woman fifty-four years old. To these statistics the author adds a case of his own, the only one seen by him during a venereal practice extending over more than ten years. The patient was a merchant thirty-five years old, and the chancre was situated on the right tonsil. His wife, who was pregnant, had a chancre on the gums. She gave birth to a child who soon presented syphilitic symptoms, and a few months later the wet-nurse of the infant acquired a hard chancre of the left nipple.

## Editorial.

### THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

“He laughs best who laughs last.”

THE previous issue of this JOURNAL contained a condensed report of the work accomplished at Washington, during the recent Congress, by the American Association of Genito-urinary Surgeons.

The quality of this work stands out prominently in the names of the writers, the range of the subjects, and the material itself. No section of



the Congress was better attended, in none was there manifested a greater desire to courteously exchange opinions for the general benefit.

The judgment passed upon an undertaking depends upon its fruits, and the results of the labors of this particular association leave it beyond question that the organization had a reason for existence, and that it will live to justify itself even more thoroughly than it has already done.

The sneers that have been heaped upon it since its inception by the London "Lancet" need no stronger rebuke than an exhibit such as the December number of this JOURNAL presented to its readers. The ripeness of the wisdom of that venerable sheet smacks of decay, and suggests the idea, from its very puerility, that crystallization has overtaken it and that second childhood is at hand.

If the profession in England is not up to the age and can not recognize that a grouping of the maladies of a special set of organs forms a legitimate field for special research, it is to be regretted; but even that conservative people will eventually see the light. If they can not recognize the drift matters are taking in their own country with such leaders as Sir Henry Thompson, Mr. Reginald Harrison, Mr. Henry Morris, and many others, they may do well to glance over at the Continent and inspect the positions assumed by Ultzmann, Joseph Englisch, Felix Guyon, Reliquet, and hosts of others. They may object to it, but can not ignore the fact that there is an admirable medical journal in France devoted exclusively to the maladies of the genito-urinary organs, another in Spain, to say nothing of this JOURNAL, which gives a large share of its attention to the same field.

In this country the advantage of grouping genito-urinary surgical matters with a study of the general subject of syphilis has been long recognized, and many professional chairs in medical colleges here are filled with the express intention of covering this ground. The ground makes itself and the workers find it ready.

The association was organized for mutual scientific advancement. No parade was made of the fact, and the membership is intended to include only such as have made more or less of a special study of the subjects treated, and already accomplished some good work in the field.

The "Journal of the American Medical Association," that self-appointed standard of all that is ethically noble in American medical circles, pronounces that it is lawful for a physician following a special line of study and practice to indicate the fact by printed words upon his business card.

Such printing upon a physician's card has been decided in council by the American Association of Genito-urinary Surgeons to be just cause for refusal to receive an applicant within its fold.

The association is an honest combination of workers. It received at its

late meeting some admirable papers from distinguished foreign gentlemen who could not be personally present, and many good wishes and sincere expressions of regret from other invited guests.

The old woman with her broom upon the sea-shore found the rising waves too much for her. It might be well for the "Lancet" to re-read that fable and ponder upon it.

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## Books and Journals Received.

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Second Annual Report of the State Board of Health and Vital Statistics of the Commonwealth of Pennsylvania.

Report of the Department for Diseases of the Skin in St. Thomas's Hospital, 1885 and 1886. By J. F. Payne, M. D., F. R. C. P.

Specimens from a Case of Varicella Gangrenosa. By J. F. Payne, M. D., London. [Reprint.]

Multiple Neuro-fibromata in Connection with Molloscum Fibrosum. By J. F. Payne, M. D. [Reprint.]

A Case of Rhinoscleroma. By J. F. Payne and Felix Semon, M. D. [Reprint.]

La Lepra es Contagiosa. Por el Dr. D. Enrique Robelin, Habana.

Ueber doppelte Primärsyphilide à distance. Von Dr. A. Ohmann-Dumesnil. [Reprint.]

The Treatment of Lupus by Scraping and Puncture. By Alfred Sangster, B. A., M. B. Cantab.

On some Indications for External Urethrotomy, with a Case of Unusual Difficulty. By L. Bolton Bangs, M. D. [Reprint.]

Remarks on Endoscopy with the Electric Light. By Reginald Harrison, F. R. C. S. [Reprint.]

Report on the Progress of Genito-urinary Surgery. By E. R. Palmer, M. D. [Reprint.]

Personal Observations on Skin Diseases in the Negro. By Robert B. Morrison, M. D. [Reprint.]

Ueber das Oleum Cinereum im Vergleiche zu den Calomel-Praeparaten. By Dr. J. Trost. [Reprint.]

Einspritzungen von Salicyl- und Thymol-Quecksilber zur Syphilis-Behandlung. Von Dr. J. Jadassohn und Dr. E. Leising.

Des érythèmes polymorphes et des nodosités pseudo-rheumatismales éphémères survenant chez les syphilitiques. Par Henri-Charles-Aubert Testu. Thèse.

Nouveau procédé pour guérir les rétrécissements de l'urèthre rapidement et sans aucun danger. Par J. A. Fort.

Ueber die Verwendung des grauen Oeles in der Syphilistherapie. Von Prof. Dr. Eduard Lang. [Reprint.]

# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### THE QUESTION OF RELATIONSHIP BETWEEN LICHEN PLANUS (WILSON) AND LICHEN RUBER (HEBRA).\*

By A. R. ROBINSON, M.B., L. R. C. P. AND S. EDIN..

Professor of Dermatology in the New York Polyclinic ; Professor of Dermatology and Pathology in the  
Woman's Medical College of the New York Infirmary ; Member of the  
American Dermatological Association, etc.

*(Continued from page 13.)*

**H**ISTOLOGY.—The changes occurring in the skin in lichen planus have been studied by Colecott Fox, Crocker, myself, and others. Colecott Fox ("British Medical Journal," 1880, p. 398) thinks the disease should not be classed among the inflammatory affections of the skin, as he considers no true inflammatory action is present. According to this observer, the papules owe their origin to persistent neuro-paralytic hyperæmia and its results; namely, dilatation of the blood-vessels and engorgement of the tissues with blood, emigration of leucocytes, œdema, hypertrophy of the various structures, and slight desquamation. Crocker ("Lancet," 1881, p. 284, and "Diseases of the Skin," 1888) describes the anatomy of the lesions as follows: "A vertical section through a recent papule reveals a mass of cells like leucocytes, and imbedded in this are sometimes seen fragments of the fibers of the corium, in the most superficial part of which the effusion has taken place. The condition of the rete varies. When the effusion of leucocytes is considerable—*i. e.*, when the process is acute—the rete is forced upward and is very little thickened, or indeed may even be thinned in the center, slight thickening being evident at the sides only and in the immediate neighborhood of the papules.

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\* Read in part before the American Dermatological Association at the Congress of American Physicians and Surgeons in Washington, 1888.

When the inflammation is not so acute, the rete is greatly thickened. The thickening compresses the cell effusion below it, and obliterates some of the papillæ, while others are enlarged by the downgrowth of the interpapillary processes. Thus, in the one case the cell effusion, and in the other the thickened rete, forms the papule. The horny layer is only slightly thickened except in the center of the papule in the less acute form, where it forms a sort of conical plug fitting into a depression of the rete, its apex corresponding to the orifice of a sweat duct. The desquamation of this plug is the cause of the central depression. In a papule with a hair in the center there was thickening of the rete adjoining the hair-follicle, slight effusion at the angle of the follicle and rete, and perhaps slight thickening of the upper part of the hair-follicle; the lower part was entirely unaffected. In sections from the border of a patch there was enormous thickening of the rete."

Lemoine, G. ("Note sur une variété de lichen plan," "Annales de dermat.," 1883, p. 327), examined a hypertrophied papule and found the epidermis thickened, the papillary layer the seat of active inflammation, and the deep part of the corium sclerosed. The corneous layer was greatly developed, forming thick layers, which sometimes passed deeply into the derma. The superficial part of the corium was composed almost exclusively of embryonic corpuscles which invaded the papilla and took the place of the normal tissue. There were many pigment granulations disposed in groups around the blood-vessels. In the deep derma were many elastic fibers; the connective tissue was close-meshed; the sweat-gland coil was surrounded by sclerosed tissue, and outside that a round-cell collection, while the epithelium showed signs of inflammation. The rete varied in size, the first row of cells had disappeared, and the granular layer was very thick. He considers the process an inflammatory one, commencing in the walls of the blood-vessels, and thinks that the arterioles and capillaries of the deep derma are first affected, and that the epidermis is affected last.

According to Neumann ("Lehrbuch der Hautkrankheiten," 5 Aufl., Wien, 1880), the whole process is a circumscribed inflammation, especially of the upper part of the cutis, with a special affection also of the sweat-glands. An examination of the drawings of lichen ruber and lichen planus, in Neumann's work, will show how different the anatomical changes are in the two diseases.

Caspary, J. ("Ueber Lichen ruber," "Vierteljahrs. f. Derm. u. Syph.," 1888), examined recent and old papules, and found in the former the upper part of the corium infiltrated with round cells—an inflammatory condition, and not a parakeratosis, as described by Auspitz. In old papules the epidermis was elevated by degeneration and disappearance of the infiltrated subepithelial connective tissue.

In Kaposi's case of lichen ruber moniliformis—a case of lichen planus—inflammatory changes similar to those described above were present.

My own observations, published in 1883 (“*Lichen Ruber and Lichen Planus*,” “*New York Med. Record*”), showed that the papules of lichen planus owed their origin primarily to an inflammatory process occurring in the papillæ and upper part of the corium, although in old lesions there is also hypertrophy of the epidermis. As I have studied many sections since that paper was published, I will here describe the appearances found in the different sections :

In Fig. 1 is shown under a low power a section of two very small pin-head-sized papules so closely seated that, according to the naked eye, very little normal tissue was present between them.

The papules were elevated, reddish in color, roundish, and had a flat, shining surface without a central depression. The lesions were from an area in which many violaceous, angular, flattened papules with a central depression were present. The section is drawn with a low power, and the lesions were not of very long standing. The corneous layer was thicker than normal throughout the whole extent of the section, but was least thickened in the central part which corresponds to the space between the papules. The cells in this section were not flattened to form dense layers, but the contour of the individual epithelia is well marked. The cohesion between the epithelia was not great, as shown by the spaces free of cells. The stratum lucidum could not be distinguished, and certainly was not increased in size. The granular layer of the rete was thickened over the papule area, and the granules very distinct, so that this part of the section colored with hæmatoxylin appeared as a dark-bluish band. The rete was thickened very much in the papule on the left side of the drawing (the one nearest *b*), and in the other papule it was also thickened, although not to the same extent. The interpapillary projections extended here and there deep downward into the corium, and in other parts they were absent. The direction of these projections was generally downward and outward from the center of the papule, and sometimes at the periphery of the lesion they were more inclined to a horizontal position. The papillæ were either absent, a result probably of the round-cell collection beneath, or



FIG. 1.—SECTION OF TWO SMALL PAPULES OF LICHEN PLANUS.

A, corneous layer; B, rete; C, cell collection in upper part of corium and papillæ; D, muscle bundle.

appeared much enlarged from the increase in length of the interpapillary rete. In the parts of the section corresponding to the lesions the connective tissue directly beneath the rete contained only a few round cells, and there was very slight inflammatory changes of the tissue, but the greater part of the papillae and the upper portion of the corium was filled with round cells, the collection being pretty sharply limited both at the sides and base (*c*). Where this collection was very dense the normal structure of the part was no longer recognizable, but at the margin and deeper part of the corium the round cells were present around the blood-vessels, and not limited to the upper side, as mentioned by Colcott Fox. The tissue of the deeper parts of the corium was unchanged except in the blood-vessel area, as already described. The muscle bundle (*m*) did not appear to be hypertrophied. The cell collection in both papules was about equal in amount, while the rete in one was not much changed, so that the cell infiltration was not likely produced by pressure upon the corium by the thickened rete.

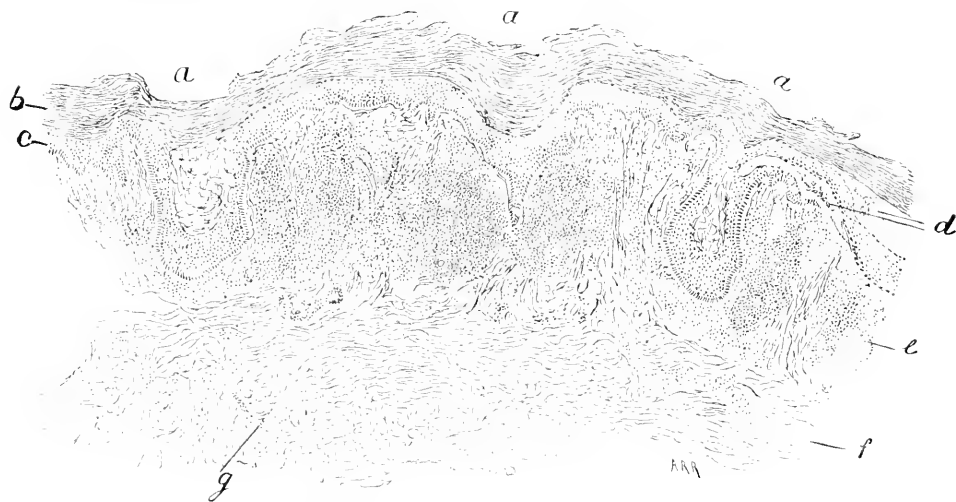


FIG. 2.—SECTION OF A RECENT PAPULE OF LICHEN PLANUS.

*a*, situation of hair-follicle orifice; *b*, corneous layer; *c*, rete; *d*, space between rete-epithelia, and between rete and corneous layer, containing exudation from blood-vessels; *e*, round-cell collection in papillae and upper part of corium; *f*, deeper part of corium; *g*, round-cell collection about blood-vessels.

In Fig. 2 is represented under a low power a section of a papule of several months' duration, according to the patient. The papule, the size of a small pea, situated over the skin, was sharply limited, elevated, red, and showed neither scaling nor a central depression. There was a large number of similar lesions upon both legs, and some upon the forearms. In this section the corneous layer was greatly thickened, and the cells were arranged to form dense lamellae. Looking at the thickness of this layer,

and the unevenness of its upper part, it seems strange that there was no desquamation present. The stratum lucidum was indistinct. The granular layer was thicker than normal in some parts, and not in others. The rete was but slightly increased in thickness, and the cells were lying, as a

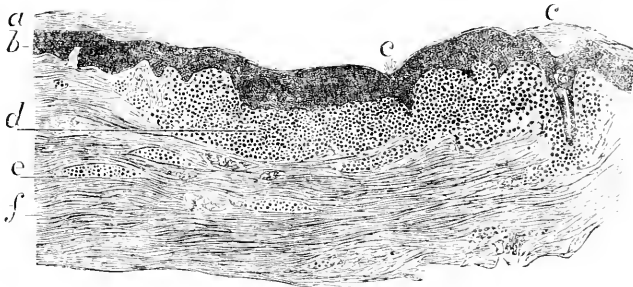


FIG. 3.—SECTION OF A PAPULE OF A LICHEN-PLANUS LESION AND SOME NORMAL SKIN ON BOTH SIDES.

*a*, corneous layer; *b*, rete; *c*, orifice of sweat-duct; *d*, round-cell infiltration; *e*, blood-vessel; *f*, deeper part of corium.

rule, with the long diameter in a horizontal direction. There was no increase in length downward of the interpapillary rete. The papillæ were not enlarged. The corium showed changes similar to those described as existing in Fig. 1, except that the round-cell collection was very slight, as a rule, in the papillary and subpapillary portion of the corium. The inflammatory exudation of a serous character was of sufficient nature at one point to cause a transudation into the epidermis and produce a microscopical vesicle (see *d*). This condition was probably caused by external irritation (scratching?). In this section the inflammatory changes, as shown by the very great round-cell collection in the corium, appear to be the principal part of the pathological process. The cell collection here is too deeply seated to arise from pressure by the rete even if this structure were thickened, but the increase in thickness was too slight to exert any irritant action. No sweat-glands were present in this lesion, and the papule was not umbilicated.

In Fig. 3 is represented a vertical section of a papule of a few weeks' duration, the section including some of the surrounding normal skin, especially on the left side. The papule corresponds to the dense, round-cell collection to be observed in the papillary region and upper part of the corium. The corneous layer over the papule was very thin, consisting of one or two layers of flat, horny cells. This thinness of the corneous layer was observed in both recent and old papules in which there was a depressed center, and consequently is not an artificial condition resulting from manipulation of the section. Whether the corneous layer was previously thicker than normal and desquamated later, or was imperfectly developed

from the commencement of the papule formation, I am not capable of stating. Outside the papule region the corneous layer appeared to be normal. The granular layer was very much thickened. The rete was thickened in some places, especially in the central part of the papule-area. Papillæ were absent over the greater part of papule region. The papillary layer and upper part of the corium were occupied by a sharply limited dense round-cell collection, as in the other sections. At the periphery of this cell-collection the blood-vessels were dilated and filled with corpuscles, and a considerable number of emigrated corpuscles was present in the perivascular region. The deeper portion of the corium appeared to be normal, except that some of the blood-vessels were dilated and surrounded by a few emigrated corpuscles.

In Fig. 4 is shown a section of a similar papule to that drawn in Fig. 3, but under a higher power. The corneous layer is absent. The rete is thicker than normal, and the epithelia throughout its whole extent are

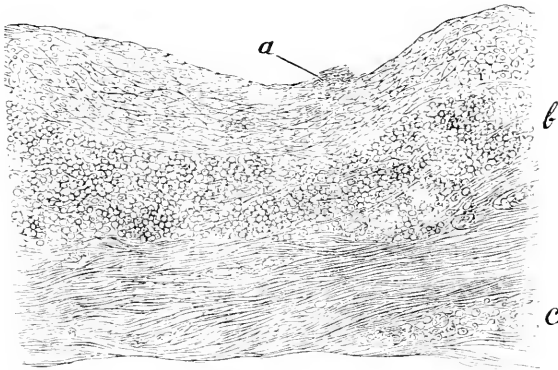


FIG. 4.—SECTION OF A PAPULE OF LICHEN PLANUS MORE HIGHLY MAGNIFIED THAN IN FIG. 3.

*a*, orifice of sweat-duct ; *b*, round-cell collection in upper part of corium ; *c*, region of a blood-vessel.

more or less flattened, with the long diameter parallel to the general surface. This flattened condition of the epithelia of the rete is characteristic of many papules of lichen planus, and I am inclined to regard it as depending upon the cell infiltration beneath pressing upon them while from some cause (sweat-duct?) they are prevented from escaping by

change of place from the pressure. According to Boeck, it is the result of an expansion in a horizontal direction of the epidermis. The granular layer was very thick, consisting of five or six layers where the rete was thick. This thickening of the granular layer is almost always present in lichen planus, and may vary much in amount in different parts of the same section. The thickness of the rete varies also very much, but in sections examined by me it was usually much hypertrophied in the sweat-duct area. In many places within the area of a recent papule it may be unchanged, or even appear as though it were thinner than normal.

In Fig. 4 the papillæ are no longer discernible, the dense cell collection in the corium and the flattened rete being so closely united that in many



places no line of separation could be seen. This cell collection is as dense and as sharply limited as in the syphilitic papules, and hence produces a lesion having many similar objective characters—as elevation, sharp limitation, density, color, and shining surface. In Fig. 4 almost all trace of the original connective tissue of the part is lost and its place is occupied by this round-cell collection. When the round cells undergo later a fatty degeneration, there must be an atrophy at the seat of the lesion, just as in syphilis. In the deeper parts of the corium the changes are similar to those already described. At *a* is seen the orifice of a sweat-gland, and as this structure has been observed by Crocker and others as well as by myself in umbilicated lesions, and running through the central part of the papule, it seems reasonable to suppose that it is the principal cause of the small depression to be observed in many recent lesions. That this central point does not depend upon anatomical changes in the elements of the papule is shown by its frequent absence from lesions. This central pin-point depression should not be confounded with the depressed center seen in lesions undergoing a degenerative change. This latter results from a sinking in of the central part of the papule, and in some cases, at least, from the thinness of the corneous layer, as in Figs. 3 and 4. Some of the early observers of lichen planus stated that the small central depression corresponds to a hair-follicle, but microscopical examination by Crocker and myself has shown that lichen-planus papules rarely form around hair-follicles, and consequently the naked-eye guess of the cause was not a fact in this case.

From the above study of the appearances presented by recent lesions of lichen planus, it is clear that the process is an inflammatory one, and not primarily a hypertrophy of the epidermis either of the rete or of the corneous layer. The inflammatory process occurs especially in the papillæ and upper part of the corium, and the cell infiltration from the upper subpapillary horizontal plexus of blood-vessels does not come from the upper surface of the vessels alone as the cells surround the vessels; and the same is true of the vessels which do not run horizontally. The changes observed in recent papules in the corneous and rete layers are so variable that they can, I think, be regarded as secondary conditions.

It has been stated that the lesions of lichen planus are never vesicular in character, although bullæ have been observed by some writers, and I have seen vesicles form after scratching a patch of chronic lichen planus. The patient from whom Plate II was taken informed me that vesicles were liable to form beneath the white pin-head-sized points unless she removed these bodies.

In Fig. 5 is shown a microscopical vesicle from a patch of chronic lichen planus. The serous collection is situated in the lowest part of the rete, the base being formed of flattened, ill-defined rete epithelia, and the

contents consisting of clear liquid and a little granular detritus. This section shows a greatly thickened corneous layer, a thickened granular layer, a thickened rete, and a corium infiltrated with exuded round cells. The granular layer is apparently very thick at one part, but that is because

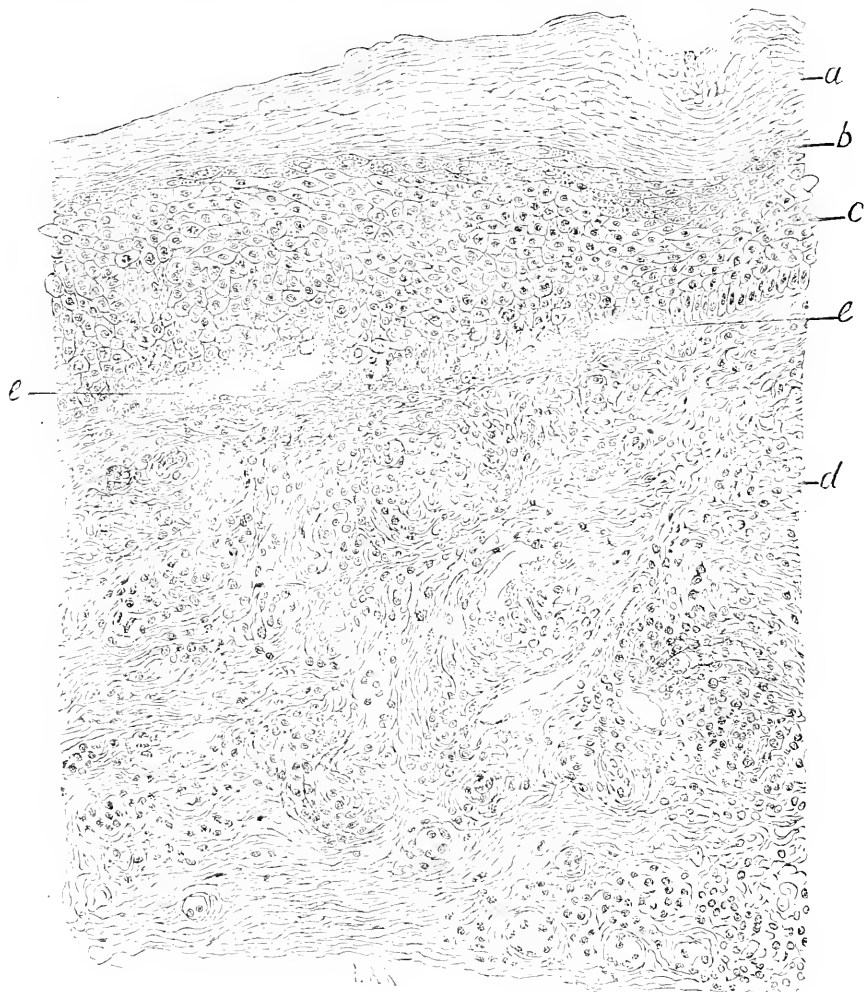


FIG. 5.—SECTION FROM A PATCH OF CHRONIC LICHEN PLANUS.

*a*, corneous layer ; *b*, granular layer ; *c*, rete ; *d*, corium ; *e*, microscopical vesicle.

this region corresponds to a follicle area. This deeper situation, in places, of the granular layer is also found in normal skin, particularly around sweat-ducts, and, in my opinion, does not represent an early change of the rete-cells. Directly over the vesicles many of the rete epithelia have an

indistinct outline, and some show a dilated transparent nucleus—changes caused by disturbance of nutrition consequent on the inflammatory process. In this drawing it will be noted that the round-cell infiltration is much less than in the recent lesions already described, while there is a marked increase in the size of the connective-tissue corpuscles. The cell infiltration extends also somewhat deeper than in recent lesions, although it did not extend below the parts represented in this figure. There is in this section the conditions produced by a chronic inflammation with round-cell infiltration, and but little serous exudation, consequently the epidermis would not undergo such degenerative changes as occur, for instance, in an acute eczema.

The limits of this paper will not permit me to enter more fully into a discussion of the anatomical changes to be seen in the previous sections, but enough has been described to obtain an idea of the nature of the process causing the lesions, and for purposes of comparison with the changes observed in lichen ruber.

I will now describe the appearances presented by sections of the skin containing the pin-head-sized white spots. These “pearls” have been

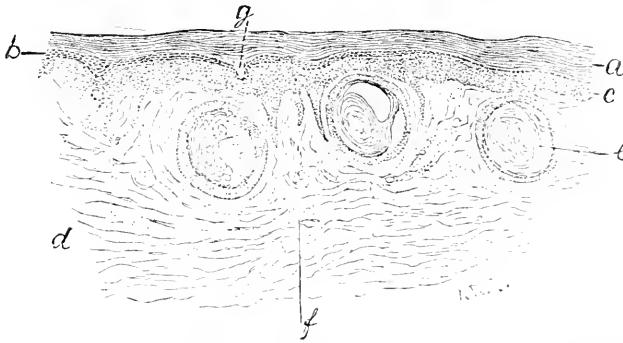


FIG. 6.—SECTION OF CHRONIC LICHEN PLANUS SHOWING THREE PEARLS.

*a*, corneous layer; *b*, granular layer; *c*, rete; *d*, corium; *e*, epidermic pearl; *f*, round-cell infiltration; *g*, orifice of sweat-duct.

described as lying in follicles—hair-follicles, I presume, have been meant. An objection to that view would seem to be the number of these “pearls” in a single pea-sized papule, a greater number than there probably is of hair-follicles in that sized area. Then I have never been able to find a hair just where a single “pearl” exists, still that would not be positive proof that they do not correspond to hair-follicles, as the hair could have already fallen out. The question is one to be settled by the microscope alone, and does not admit of solution by guessing no more than does the cause of the central depression.

In Fig. 6 is shown three “pearls” in one section. They are all situ-

ated in the pars papillaris and upper part of the corium. They appear to be separate from the rete, and there is no prolongation downward into the deep corium or the subcutaneous tissue, as would be expected to occur if they were connected with hair-follicles. The central part of each is made up of tissue similar to that of the corneous layer (*e*); outside of that is a dark layer similar to the stratum granulosum, and the peripheral part is similar to the rete. It will be observed that in each there is considerable space free of tissue, just as is often observed in the upper parts of the corneous layer. The corneous layer is thickened, as is also the granular layer and the rete. Toward the right side (*b*) the granular layer is much thicker than at the other side (*c*). There is a characteristic prolongation downward of the rete at four different places in the central part of the drawing, and in some of the sections I could trace a connection between these prolongations and the "pearls." In the corium there is but a limited round-cell infiltration.

In Fig. 7 are represented under the same power as Fig. 6 two "pearls," with a hair-follicle between them. The epidermis and corium show similar changes to those in Fig. 6. The smaller "pearl" has the same situation as the three already described, but the larger one is not round but egg-shaped, and the small end extends to the corneous layer. The arrangement of the dried epithelium of the central part is like that of a dense corneous layer. The granular layer is very distinct in both these "pearls." Between these two epidermic nests is to be seen a small collection of cornified epithelium arranged in a somewhat

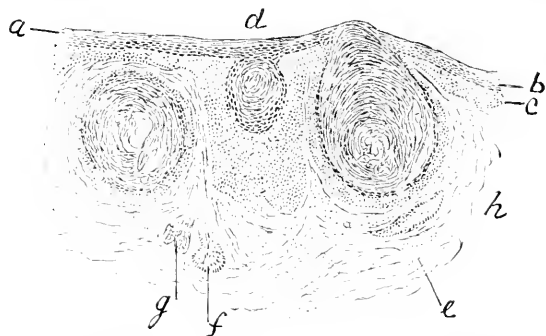


FIG. 7.—SECTION OF CHRONIC LICHEN PLANUS SHOWING TWO PEARLS, WITH A HAIR-FOLLICLE BETWEEN THEM.

*a*, corneous layer; *b*, granular layer; *c*, rete; *d*, hair-follicle area; *e*, round-cell infiltration; *f*, hair-follicle; *g*, sebaceous gland; *h*, corium.

similar manner, and surrounded with a very

thick granular layer and rete. It corresponds to a hair-follicle. It seems probable that a "pearl" could form at this place, but I have not in the dozen "pearls" that I have examined found any hair-follicle in connection with a fully developed "pearl."

In Fig. 8 are represented two "pearls," one of which is in direct connection with the corneous layer, and it can be readily seen that they have a similar structure as the epidermis, there being a direct continuation of the layers of the epidermis with the layer of the "pearl," and they showed

under the microscope similar structures. At the lower and left part of *d* is a small "pearl" commencing to form—at least I do not think that it represents a small section of a large "pearl." In this drawing a hair-follicle is well shown, and yet there are no signs of a "pearl" forming.

These three sections are all shown under a low power so as to give an idea of the situation of the "pearls," and to show as many as possible in

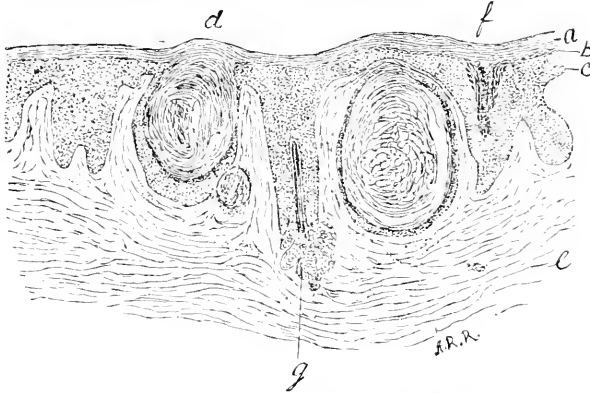


FIG. 8.—SECTION OF CHRONIC LICHEN PLANUS.

*a*, corneous layer; *b*, granular layer; *c*, rete; *d*, "pearl"; *e*, corium; *f*, sweat-duct orifice; *g*, sebaceous gland in connection with hair-follicle.

one drawing. A consideration of these figures shows that these epidermic collections do not correspond to hair-follicles or other gland structures of the skin, but are caused by growth downward of the rete and a transformation of the rete-cells to granular and corneous cells as in the normal process upon the free surface, or as occurs in a more or less perfect form in some cases of epithelioma. These figures also show that in chronic lichen planus the epidermis is thickened in all its layers, while the round-cell infiltration is much less than in the acute lesions. This is what is apt to occur in the ordinary inflammatory affections of the skin, the acute stage showing much cell infiltration and little epidermis formation, and *vice versa* in chronic inflammations. On the other hand, affections of the epidermis—hypertrophies—show more round-cell collection the greater the hypertrophy, as, for instance, in psoriasis and epithelioma. If in lichen planus the round-cell infiltration was caused by pressure from the epidermis, consequent upon the increase in its thickness, we should find it most marked in the chronic forms of the disease. To prove that a process is an epidermidosis, it must be shown that the primary changes occur in the epidermis, and this can only be done by examining the most recent lesions. Lesions of a few weeks' duration, for instance, showing a thickened epidermis, prove nothing if with this hypertrophy there are inflammatory changes in the vascular tissue beneath. Relying upon the great

amount of cell infiltration in recent papules, and the frequent slight epidermic changes, it seems to me that lichen-planus lesions owe their origin primarily to an inflammatory process taking place in the papillary layer and upper part of the corium, and that later the epidermis undergoes hypertrophy and aids in its formation. The small central depression depends upon the sweat-duct and the depressed center to a fatty degeneration of the round-cell infiltration and a flattening of the rete, together with, sometimes at least, a desquamation of the corneous layer over the central part.

I have examined the nerves by Weigert's method, but did not find any abnormal condition. Neither have I been able to find organisms, although inclined to believe that the lesions depend upon them.

*Treatment.*—The majority of dermatologists depend upon arsenic for the cure of the disease, but if we carefully study the results of this agent in the cases reported by its advocates it will be seen that its action is anything but prompt and decided, although in the majority of the cases there was considerable improvement produced, and some were cured. That it is of benefit in many cases no one can deny, but that it is a reliable remedy in all cases, or perhaps even in a majority, has not been my experience; and I find that some other observers hold similar views, for Tilbury Fox, for instance, says that many of his cases were made worse by its use. If the disease is a neurosis, one would expect to obtain benefit from it, but, although I have ordered it in almost every case that has come under my observation, the number of them cured by it has been very few indeed. Perhaps the result in my hands depended upon the amount given, as the dose ordered was the same as I prescribe for psoriasis—from fifteen to thirty-five drops daily, and I have lately read that it may be necessary in some cases to give sixty to seventy drops of Fowler's solution daily. If such doses do cure it, then my statement as to its value has no weight; but that is not yet settled. In New York city many persons suffer from malarial infection, and arsenic should benefit cases associated with that condition. Alkalies are of much benefit in some cases, and I have seen in rheumatic subjects the eruption disappear within a couple of weeks from the use of iodide of potassium and colchicum. Rapid improvement has been observed after using other remedies, but for the present discussion the value of arsenic and alkalies specially demand our consideration. If lichen planus and lichen ruber are similar diseases, depending upon the same aetiological factor, and lichen ruber the severer form of the disease, then arsenic should control the former disease, as it has a decided effect in the latter. Although I maintain that its action is frequently *nil*, nevertheless, even were it of benefit, that alone would not prove a similarity of aetiology between the two diseases, no more than it proves a relationship between lichen planus and psoriasis or pemphigus. The resistance of the

disease to arsenic in many cases, and the prompt cure of others by iodide of potassium or other means—remedies of no value in lichen ruber, as far as I am aware—show the results of similar methods of treatment in lichen ruber and lichen planus to be very different in the two diseases.

## LICHEN RUBER.

According to the first description of lichen ruber given by Hebra, the eruption consists of millet-sized, isolated, conical, bright red or brown-red, firm papules situated around hair-follicles and covered on the apex with a fine, adherent, white scale. They afterward may become obtuse, and still later flattish in form. The papules are not arranged in groups, and preserve their original size during their entire existence, never increasing by extension at the periphery, the spread of the eruption always depending upon the formation of new papules similar in size and appearance to the already existing ones. As the eruption tends to extend and occupy the entire cutaneous surface, new lesions are continuously forming, and the skin becomes more and more occupied, until finally a certain area is completely covered by them, and the neighboring papules come in contact with each other. When this has taken place, the eruption appears as a red, infiltrated patch, covered with scales, and having a dry, rough, uneven surface. At the periphery of such a patch characteristic papules are always to be seen.

The eruption tends to extend and occupy the whole cutaneous surface, and, when this occurs, all signs of papule formation cease, and the skin appears everywhere reddened, thickened, furrowed, and covered with numerous thin, whitish scales. The skin of the face becomes dry, cracked, and scaly, the lower lids ectropic, the upper lids droop. The increased thickening of the skin appears especially upon the palms of the hands and the soles of the feet, where the eruption does not appear as papules, but as great thickening of the corneous layer. In consequence of this thickening, the fingers and toes stand apart from each other, half bent, and show, besides redness and infiltration, deep fissures and rhagades. Muscular movement is interfered with, especially at the joints, so that the patient can not keep the extremities fully extended or flexed without difficulty. When the eruption is general, the nails always become affected; they are greatly thickened from a deposit of nail-substance from the bed of the nail, are of a yellowish-brown color, very brittle, and have an uneven surface. If the deposit takes place from the matrix alone, then the nail consists only of a short, brittle plate which projects from the flesh.

The nutrition of the hairs at the seat of the disease *is always interfered with*, the hair becoming thinner and replaced by lanugo hairs.

Itching may be present, but it bears no relation to the extent of the eruption, and is much less than that accompanying many other skin-dis-

cases. The eruption appears without prodromal symptoms, and may exist on unexposed parts of the body without the knowledge of the patient.

*The general nutrition always suffers sooner or later*, and the patient passes into a marasmic condition and dies, unless he previously succumb to some complication depending indirectly upon this marasmic condition, as pneumonia, pleurisy, etc. Twelve of the first fourteen cases observed by Hebra died, and almost all subsequently reported, undoubted cases of this form of eruption of any duration have been associated with grave conditions of the general system, and showed the same tendency to lead to a marasmic condition.

Such are, briefly, the clinical characters of the disease in the cases observed by Hebra, and in the unquestioned examples of the same affection reported by subsequent observers. It has been suggested by some European writers that American dermatologists are not so familiar with this disease as they are, and hence our incorrect ideas of its relationship to lichen planus; but if the literature of the subject is studied, it will appear that the disease is probably just as frequent here as it is in other countries. In support of this statement I need only refer to the seven cases reported at the last meeting of the American Dermatological Association by New York dermatologists alone.

As in the case of lichen planus, so also in that of lichen ruber, we must, I believe, take into consideration, in doubtful cases, the whole symptoms and course of the eruption before making a diagnosis, for, as was stated by a reporter in the "Vierteljahrschrift" for 1869, in discussing the entity of this disease, too much weight must not be placed upon the appearance of the primary lesions, as the red, scaly papules alone are not characteristic of lichen ruber. The presence of acuminate papules, reddish in color, covered with a scale, and showing no tendency to change to vesicles or pustules, do not, in my opinion also, justify the diagnosis of lichen ruber. If lesions with those characters justified such a diagnosis, then the mistake of regarding cases of lichen scrofulosorum, lichen pilaris (Devergie), and even of lichen simplex (eczema papulosum), as examples of lichen ruber would be frequently made.

An acute form of lichen ruber has been described by Unna ("Zur Klinik u. Therapie des Lichen ruber," "St. Petersburg. med. Wochen-schr.," 1884, No. 45; "Clinical History and Treatment of Lichen Ruber," "The Medical Bulletin," Philadelphia, 1885), but the eruption in the cases reported by him bore so little resemblance to that described by Hebra and by the other writers, who have seen undoubted cases of the disease, that, unless such cases were left untreated and watched so as to learn if they assumed later on the recognized characters of chronic lichen ruber, I do not think they should be accepted as examples of the disease. Just as the papules of syphilis may be indistinguishable from those of



lichen planus, so an acuminate scaly papule is not necessarily a papule of lichen ruber.

To make my position clear, I will quote from Unna's description of his cases :

"CASE I.—Miss M., aged seventeen, a Parisian, who had never suffered from any disease of the skin, was taken ill on January 5, 1881. Her illness began with a chill and a feeling of general indisposition and an itching eruption of the skin. On the following day the cervical and lateral regions of the neck were covered with a small papular, intensely red, itching eruption spreading upon both upper extremities and as far down the radial side of the forearm as the wrist-joint. The face, trunk, and lower limbs were entirely free. The light-red papillæ which it was said had appeared spontaneously were the size of a mustard-seed, light-red, shining, pointed like a ten-pin, and when not scratched off were covered with a small scaly elevation. . . . At no time was a transition from the papular to the vesicular stage noticeable, and scratching produced no other effect than the exfoliation of the scaly deposit of the papules. As the manifestations excluded the diagnosis of *eczema papulosum*, it could not be anything else than an acute attack of *lichen ruber acuminatus*." The eruption was treated with gauze compresses saturated with a solution of equal parts of *liquor plumbi subacetatis* and *liquor aluminii acetatis*, with a few drops of glycerin. In one week the patient was cured. In February a relapse occurred, symmetrical in appearance on both forearms near the wrist-joints, which disappeared in four days after the application of zinc ointment and acetate of lead.

In referring to this case, Unna states that "the points absolutely diagnostic of lichen acuminatus are the squamous nodules upon a non-flattened elevation, and located at the orifice of a hair-follicle."

In the other two cases reported by Unna, to prove the existence of an acute form of lichen ruber, the diagnosis was made from similar characters as in Case I, and in one of them the eruption was complicated by a moist *eczema*. For want of space, I must refer the reader to the original article by Unna for a full description of the cases.

In connection with these cases I will now quote from Tilbury Fox a description of lichen simplex, which corresponds to the *eczema papulosum* of German writers, and most other dermatologists: "In lichen simplex the papules are flesh-colored, red, smallish, sometimes very minute, more or less pointed, lasting a week or so, and followed by the development of others; the papules are usually seen on the back of the hands, outer aspect of the forearms, the neck, and the thigh. They are accompanied by a great deal of itching. The papules disappear by absorption, and *never become vesicles or pustules*. This form of lichen may last for weeks or months. As the lesions disappear there is slight desquamation. In lichen circumscriptus the papules are collected into round or roundish elevated patches, the border of the patch is well defined and papular, the surface

elevated, rough, and dry to the feel. The patches after a time get more or less scaly or inflamed, or cracked, simulating eczema, but never discharging. Their history, absence of moisture, and the dry, red, roughened base are distinctive. These cases are best treated by zinc and borax or borax and bichloride."

Vidal describes the lesions of acute lichen simplex as hard, firm, reddish elevations, rarely larger than a millet-seed, and containing no liquid. When *small they are acuminate or conical; when larger, flat, lenticular, or even hemispherical; the surface is dry, rough, and covered with small epidermic scales.* It lasts three weeks to a month, when the papules become paler, sink in, and the eruption terminates by a fine furfuraceous desquamation.

I have quoted these two excellent observers in order to compare their description of lichen simplex in general with the appearances described by Unna in his cases of acute papular eruption. Although Unna strongly repudiates the idea that his cases were other than examples of an acute form of the lichen ruber acuminatus of Hebra, yet it must appear to most dermatologists—and it has appeared to those writers who have referred to them—that they do not in any way bear a resemblance to that disease except in the form of the lesion; while in Case I, which I have quoted, the symptoms and character of the eruption bore a close resemblance to the lichen simplex of English and French dermatologists—a form of eruption which many American dermatologists also recognize as clinically sufficiently distinctive from papular eczema as to merit a special designation.

Following or agreeing with the views of German dermatologists that lichen simplex is merely a papular eczema, the character of the lesion depending probably more upon the nature of the tissue being injured than upon the nature of the factor producing the inflammation, and being familiar with such forms of eruption as those described by Unna, I must, with all deference to the views of this writer, state that I do not consider that his cases were other than examples of papular eczema. The absence of vesicles or pustules is no objection to that diagnosis, according to Fox and Vidal, and in the case of papular eczema I described in the earlier part of this article, although the body was covered with lesions, and they had already existed two weeks, none of the lesions had become vesicular. Consequently eczema can not be excluded upon the grounds given by Unna.

If such cases as those described by Unna are examples of lichen ruber, then we are all familiar with the disease, for such cases are not rare in America; but surely no one has considered them to be acute forms of that disease, and no one, to my knowledge, has seen an untreated case assume the chronic and dangerous form of eruption described by Hebra. Only

by the reporting of such cases by competent observers can any connection be shown to exist between the forms of eruption described by Unna and those described by Hebra, for the symptoms and course are too widely different to assume a relationship from a similarity in the morphology of the lesions, even if such a similarity exists.

From a study of cases of lichen simplex or papular eczema we see how closely the lesions resemble those of lichen ruber, and when we consider how not infrequent this eruption is met with, the necessity of care in diagnosis is very evident. I will return to this subject later. At present I only wish to draw attention to the similarity in the form of the lesions in lichen simplex and lichen ruber, and between lichen simplex and the acute papular eruption described by Unna, and the dissimilarity in history between the latter and lichen ruber. I wish particularly to draw attention to the fact that in lichen simplex small lesions are generally acuminate, and larger ones flattish in shape; hence, were a diagnosis to be made upon the form of lesion alone, a combination of large and small lesions in this disease would lead to the diagnosis of a combination of lichen planus and lichen ruber upon such a subject.

*(Conclusion in next number of the Journal.)*

## A CASE OF DERMATITIS TUBEROSA OF IODIC ORIGIN.

By CONDUCT W. CUTLER, M. D.,

Assistant Surgeon to the Venereal and Skin Department of the New York Hospital.

SOON after reading Dr. R. W. Taylor's admirable article on "Dermatitis Tuberosa of Iodic Origin,"\* I had the opportunity of studying a very interesting case of this disease, in which the lesions of the three stages, into which the disease is divided by Dr. Taylor, were all typically represented at the same time. The case is as follows:

J. J., colored, American, aged forty-six years, applied for treatment at the New York Dispensary, November 25, 1888, with the following history: Several years previously he had contracted syphilis and was under treatment for some time. He had the usual manifestations of the disease, which gradually disappeared without recurrence until four weeks ago, when he noticed a large ulcer on the inner side of the fore-skin near the frænum, which made its appearance two days after connection. Thinking that it was a chancre, he at once put himself under the care of a physician, who pronounced it syphilis, and commenced giving him large doses of iodide of potassium. About a week after beginning treatment, pimples made their appearance on the face, forehead, and shoulders, which were painful and like little boils. This was taken for a syphilitic eruption, and increased doses of iodide of potassium

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\* "New York Medical Journal," November 3, 1888.

were administered. A few days afterward these pimples on the face increased rapidly in size, some of them uniting and forming tumors upon which scabs formed. These lesions were painful and accompanied by considerable heat and burning. One eyelid had become so swollen that the eye was closed, and in this condition he applied at the Dispensary for relief.

The drawings show well the appearances presented by the eruption in all its phases of evolution.

Upon the forehead were a few papulo-pustules, not unlike those of *acne indurata*, and could properly be called simple iodic *acne*. Two localized congestive swellings of the skin were present just below the left eye (Fig. 1)



FIG. 1.

in the form of nearly round patches. In these patches were plainly seen little cribriform openings, out of which were oozing pus and sebaceous matter.

The left upper eyelid was greatly tumefied (Fig. 1), so that the patient was unable to raise it, along the margin of which was a number of trumpet-shaped openings apparently leading to small abscess-cavities, for, upon pressure, pus could be made to exude in small quantities. Palpation showed the tumor to be soft and spongy in structure, almost fluctuating. Near the

central margin the pus had dried in a hard mass, giving the eyelid a pointed appearance, beautifully shown in Fig. 1, which, when removed, revealed typical cribriform openings.

The tumors had further developed on the right side of the face, and upon the surface of the one situated under the lobe of the right ear (Fig. 2) pus had dried, forming a hard, thick, yellowish crust, which showed, however, upon being removed, the same typical cribriform openings.

The tumor situated near the center of the right cheek (Fig. 2) represented the last stage of the eruption. It was at least half an inch in height and a



FIG. 2.

little larger than a quarter of a dollar, and around it, as around the other tumors, was a small, thin area of redness. This tumor was covered with a dry crust, which, when removed, presented a secreting vegetating or fungating surface. The cribriform openings had mostly closed, the secretion coming directly from the surface of the lesion.

This case, therefore, presented all the lesions so carefully described by Dr. Taylor, and still further, I think, warrants the term given the disease by him—viz., “*Dermatitis Tuberosa*.”

150 WEST FIFTY-THIRD STREET, *December 24, 1888.*

## MOLLUSCUM CONTAGIOSUM—A PRELIMINARY REPORT.\*

BY HENRY W. STELWAGON, M. D.,

Of Philadelphia.

**O**PINION as to the histological formation and the clinical behavior of mollusum contagiosum is at the present day tolerably well defined, but the same unanimity can not be said to hold in regard to the subject of its contagiousness. English writers as a body, as is well known, take the side of the affirmative on this question; the Germans and French, on the contrary, take an opposite view. American opinion, as a whole, has followed the Germans. The latest American contribution to the literature of this disease, by Allen, based upon an observation of fifty cases occurring in an institution, presents, as the writer claims, facts which appear to prove that the disease has contagious properties. My own experience, which I shall here briefly relate, seems, contrary to preconceived prejudices, to have much in common with that of the last-named writer.

The cases comprised in this report number thirty-two, and were observed, so to speak, in four groups. The first series, numbering four cases, came to my notice at the Children's Hospital, of Philadelphia, in 1881 or 1882, through the kindness of Dr. Henry R. Wharton. My notes of these cases, unfortunately, have been mislaid, and the exact data can not therefore be given. I remember, however, that the disease was first seen in one of the crippled inmates, and that soon afterward three other cases among his fellows in the same ward were observed. The ward contained twelve patients, all of whom were confined to bed. The disease was of the moderately developed type, each case showing from three to a dozen lesions, and these chiefly upon the face. This was the extent of the spread of the disease, although, it must be stated, the hospital contained a tolerably large number of children.

The second group I saw in the latter part of March, of last year, at St. Vincent's Home for Children, with the attending physician, Dr. Joseph Lopez. In this series were thirteen cases, all of which had made their appearance within a few months. In these thirteen, with one exception, the mollusca were seated upon the face only; in the one excepted, in addition to those on the face there were two upon the hands. This distribution I mention especially for the reason that at the same time scabies was prevalent at the Home, and if irritation strongly favors the production of mollusum, as suggested by some writers, then the three or four

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\* Read before the American Dermatological Association, at the Congress of Physicians and Surgeons, Washington, September 19, 1888.

cases of this series who had the itch also, should have shown mollusca upon the parts affected by this disease; but, on the contrary, while all parts of the body except the face gave evidence of a well-marked scabies, the face alone was the seat of the molluscum tumors. Moreover, the single case showing molluscum upon the hand was entirely free from the itch. The affection—molluscum contagiosum—had been introduced into the institution by one of the inmates, and subsequently showed itself in the other children. The Home contained in all one hundred and fifty children. The number of lesions in the individual cases varied from one to twenty, and in size from a pin-head to a large pea. In fact, the eruption was of the ordinary character, and under hygienic and therapeutic measures soon disappeared.

The cases of the third group were observed last autumn at the service of the Philadelphia Dispensary for Skin Diseases. This group consisted of three cases, all in the same family. The affection first appeared in the daughter, a young girl of twelve years, and consisted of six characteristic lesions—three on the face, one on the trunk, one on the thigh, and one on the arm. When first seen the disease had lasted several weeks. Shortly afterward the father of the girl developed a lesion on the neck, and at the same time the sister presented a lesion on the thigh. In these three cases there was a marked disposition for the mollusca to become pedunculated, and to gradually disappear by ulceration.

The fourth series I saw in the past month, at the same institution at which the cases of the second group were observed. It consisted of twelve cases, and in this instance was apparently traceable to two imported cases, all cases of the former group having been cured or discharged. In this series, also, the disease was of a moderately developed type, and displayed no unusual manifestation.

These four groups constitute all the cases of this disease, with possibly one or two exceptions, which have come under my observation in a period of thirteen years, and it must be admitted that, with this experience before me, my former belief in its non-contagiousness has been somewhat shaken. Various attempts at inoculation were made, but never with any further result than the appearance of insignificant and evanescent inflammatory papules, in no way characteristic.

In studying these cases and the cases reported by others, especially with reference to the subject of contagion, three or four facts stand out prominently: First, that the disease, while occasionally occurring upon covered regions, is practically seen either upon exposed parts or parts with which the hands must of necessity come more or less in contact, as the genitalia. Second, that the disease is observed chiefly in children, and as a rule in children of the poorer classes. Third, that while it is comparatively rare to meet with single cases, it is exceedingly common for the

affection to be seen in groups or series, as in a family or an institution. Fourth, that, in admitting its contagious nature, it must at the same time be acknowledged that apparently it possesses this property only in an extremely slight degree.

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

185TH REGULAR MEETING, *December 19, 1888.*

DR. KEYES, *President, in the Chair.*

**Inflammatory Fungoid Neoplasm.**—DR. SHERWELL presented a case of this affection—at least, that was what for the present he preferred to call it. The patient was a man, about sixty-two years of age. He had been badly burned on the back of his hand in infancy. The present disease occupies the site of the burn, and also extends beyond it. It occurs in the form of a verrucous growth, of horny nature, which is healing in the middle and tending to spread at the periphery. The color of the growth is a blackish green.

DR. FOX said, in the discussion of the case, that it seemed to him to be one of epithelioma, with the formation of a cutaneous horn. He had seen similar cases, one on the back of the hand, one on the cheek, and one at the base of a cutaneous horn.

DR. KEYES asked if there was not always a tendency to the production of epithelioma at the base of cutaneous horns?

DR. FOX said that Pancoast had reported cases in which such a tendency was not shown.

DR. ELLIOT thought that there was such a tendency, and that the danger from cutaneous horns was the frequent development of epithelioma at their base.

DR. BRONSON would regard the case as one of epithelioma, but not necessarily of cutaneous horn. There was certainly blackened corneous tissue, but he did not regard it as horny.

DR. STURGIS would call the case one of papilloma cutis, not epithelioma.

DR. FULLER had seen a similar papillomatous growth resulting in epithelioma. He would like to ask if part of the growth, at least, might not be keloid on a cicatricial base?

DR. ALLEN thought that the disease was an epithelioma, and the hardness, conformation, and stratified condition of a part of the growth were decidedly characteristic of cutaneous horn. He did not believe the disease to be a keloid.

DR. KLOTZ said that the outer wall reminded him of those cases of lupus erythematosus that he had reported. He would not be understood as saying that the case was one of the latter disease, but would only suggest the possibility of it. It was also quite possible that a keloid lay at the bottom of the



trouble, if the original scar of the combustion had extended to the seat of the disease. The papillary and horny growths he did not consider as necessarily essential features of the original process, as they might develop on the bases of different diseases.

DR. ROBINSON pronounced the case to be one of papilloma, not of epithelioma at present, as there were too many characteristics of a common wart. It was not likely that there was a keloid at the bottom of the trouble, as in a keloid the papillary layer of the skin was absent, and hence a papillary growth could not occur.

DR. KEYES did not see any characteristics of keloid, nor evidence of epithelial ulceration, in this particular case.

DR. STURGIS said that while at present he did not find distinctive marks of epithelioma, he thought that the case would become one on account of the patient's age. At present the base was unlike either keloid or epithelioma. He would certainly not think of the disease being lupus erythematosus.

DR. SHERWELL said, in closing, that he believed the case to be one of epithelioma, and that it had probably started in a scar.

**Morphœa with Ulceration.**—DR. FOX then presented a case of this affection. The patient, a man, gave the following history: About ten years ago a yellowish-white, depressed spot appeared on the left cheek near the infra-orbital ridge. This gradually extended until last spring, when it was about half an inch square. It then appeared as if mortised into the skin, and was streaked with fine vessels. At about the 1st of April last the margin of the patch was cut, in shaving, and ulceration ensued. When the patient was first seen by me there was a slight crust over the ulcer, which, being removed, showed a lesion suggestive of rodent ulcer. Dr. Fox believed that the case was at first morphœa which subsequently ulcerated.

In the discussion of this case, DR. BRONSON said that he would not like to make a positive diagnosis now. He did not see good evidence of the presence of morphœa, nor did he understand why morphœa should ulcerate. Of course it might do so, but it would be extraordinary. All hypertrophied scars were not keloid, so there might be symptoms of morphœa present, but no morphœa.

DR. TAYLOR thought that the infiltration seemed to point to morphœa, but it was difficult to form an opinion, seeing the case but once. He would not like to say that morphœa could not ulcerate because no one had seen it do so. The case looked like one of morphœa he had seen that had not ulcerated.

DR. ALLEN thought the ulcerated spot might be accounted for by the cutting of the edge with a razor and the subsequent scraping. The white border looked to him like morphœa.

DR. ROBINSON said that he would not expect morphœa to ulcerate, but it might if injured. In this case the sharp limitation, the elevated, firm margin of the growth, made him believe that it was a superficial epithelioma. The disease had probably started in the scar to the right, which was the result of injury.

DR. SHERWELL would take into consideration the proneness of epithelioma to attack this region, and the exceeding rarity, to say the least, of ulcer-

ation taking place in morphœa, and would diagnosticate this case as one of epithelioma.

DR. BULKLEY had seen white patches looking like those of morphœa that were epithelioma. He recalled one case occurring on the nose of a young woman that he had diagnosticated as one of morphœa, which proved to be a very malignant form of epithelioma, and finally caused the patient's death.

DR. ELLIOT would diagnosticate the case as one of epithelioma. He had neither seen nor read of morphœa with an elevated edge, as in this case, with dilated capillaries running over it. There were also white atrophic spots outside of the growth which were not found in morphœa. We might have ulceration in scleroderma, and he did not see why it could not take place in morphœa, regarding the latter as a circumscribed scleroderma; but he would expect to see it rather over a bony prominence than over soft tissues.

DR. FOX said that the location of the patch was not diagnostic either of morphœa or of epithelioma. Dilated capillaries would be seen sometimes both in the one and the other disease. He would call attention to the long existence of the disease in this case in the form of a square, depressed, stiff, whitish, thickened patch, that came spontaneously, and was never raised above the surface. The ulceration began after injury in shaving. The margin of the patch was certainly like epithelioma, as shown by the readiness with which the curette scraped away the growth. It was very likely that an epithelioma had developed at the edge of the morphœa. The original patch could not be epithelioma. The white margin of the patch was the original seat of the disease, and had never ulcerated. It was uncommon for morphœa to become epitheliomatous, but Jamieson had reported a case of ulceration of morphœa; and we must remember Lewis's case, in which he [Fox] had diagnosticated a similar occurrence. In the latter case microscopical examination had proved the disease to be sarcoma, but the edges had seemed to him to resemble morphœa.

DR. SHERWELL remarked that in some cases of epithelioma, especially in old people, a good deal of interstitial absorption without implication of the upper layers of the skin is seen, and probably that was what had taken place here.

DR. ELLIOT said that in Lewis's case he had found evidence of sarcoma alone, and certainly nothing that pointed toward morphœa. He would like to ask Dr. Fox if in morphœa he had ever seen dilated capillaries over the edge alone, and not over the whole patch?

DR. FOX replied that such vessels were over the whole patch.

DR. TAYLOR said that there was no doubt about these capillaries. He remembered a case of a woman with morphœa which looked like erythema nodosum in color. The color was due to the dilatation of the capillaries. The purplish color would center itself in a ring; around this would be an inflammatory border, and inside this the tissues were brawny, like a billiard-ball. Wilson, Hutchinson, and Fox make mention of the border with dilated capillaries.

DR. ROBINSON believed that the red vessels were small arteries, and that we were more apt to get a purplish color from dilated veins.

**Syphiloderma Papulosum Circinatum.**—DR. KLOTZ presented a case of this eruption with the following history : R. S., a woman thirty-seven years old, who has been under his observation for over a year, and who has a clear history of syphilis. She was first seen in 1887 with a general maculopapular squamous syphilide, a seborrhœic affection of the scalp, and patches of squamous eczema on the legs. In December, 1887, she had mucous patches on the tongue and cheek; in February, 1888, a papular syphilide of the face, and ulcerated papules on the nose at the entrance to the nostril; in March, severe stomatitis, probably from the use of some aperient pills; on July 7th she appeared again with a papulo-tubercular syphilide on the face and neck, which had nearly disappeared by the end of August. After the lapse of several months she presented herself again three days ago, showing an eruption on the face and forehead and neck, which consists in a number of well-defined annular lesions. Those attaining a size of a quarter to half a dollar are surrounded by narrow but abrupt borders of elevation, covered with thin scales of a dirty yellow-brown color, leaving the central area unelevated, smooth, or bearing but very slight scales, and exhibiting but slight pigmentation. They are located principally around the angles of the mouth, on the shins, the forehead, and both nasal folds. In some places the elevated borders are running together, thus abandoning their otherwise nearly strictly annular shape. The face of the patient bears a very close resemblance to the cut of a negro's head accompanying Dr. Atkinson's paper on the "Syphiloderma Papulosum Circinatum" of Dr. Fox in the first number of the JOURNAL OF CUTANEOUS DISEASES, and I believe that there is no doubt but that this is a case of the same affection. I would ask if you find in this case features of seborrhœic eczema, such as Unna would probably do in accordance with his recent paper on this subject in the "Monatshefte für prakt. Dermatologie"?

DR. BULKLEY could not see the reason for Unna regarding these cases as modified either by an eczema or seborrhœa.

DR. ELLIOT, from certain cases he had seen, would regard Unna as right to a certain extent. He had seen the condition that Unna describes on the nose and eyebrows, giving the lesions of syphilis a dirty, greasy look, and covered at times with dirty, greasy crusts. He had met with cases of syphilis presenting symptoms such as Unna describes that had yielded very rapidly to treatment addressed to the seborrhœic condition, which before had proved very obstinate to the usual antisypilitic remedies. Dr. Unna, he thought, went too far, but he was quite willing to follow him to a certain extent.

DR. BRONSON thought that Unna was to a certain extent right in his opinion, and that a seborrhœa might modify the course of syphilis. The eczematous element was more doubtful. We have long known that when a syphilide occurs on a region where there are many and large sebaceous glands, the eruption takes on the characteristics of seborrhœa.

DR. TAYLOR said that we have recognized for years the implication of the sebaceous glands in various hyperæmic conditions and in syphilis; but this has nothing to do with an eczema seborrhœicum. He would recall Fox's case of miliary syphilis with a great deal of seborrhœa. He has now a case of nummular tubercular syphilis over a man's eye that has a good deal of scaling and might be taken for psoriasis; but we can not assume that seborrhœal

eczema influences it; that was too much of a refinement. It is simply an increased functioning of the sebaceous glands due to the irritation of syphilis. That resorcin externally and mercury internally will cure it, is not surprising. The so-called eczema-seborrhoicum treatment is simply stimulation applied to the skin causing absorption.

DR. ALLEN thought that the case did not well illustrate the condition described by Unna, and the seborrhœa had not modified it. There are cases in which such modification does occur, not in syphilis only, but also in psoriasis. He has recently treated a case of the latter disease in which there was a well-marked eruption like a corona Veneris in segments of circles along the hair margin. This condition rapidly disappeared under the use of sulphur, while the eruption of the rest of the body continued unchanged. We can not cure psoriasis with sulphur. He had tried it and failed.

DR. TAYLOR referred to a case of psoriasis of the scalp in Hebra's "Atlas," with plates of seborrhœic matter. The condition is not uncommon, and it is a well-known fact that psoriasis of the scalp is far more easily cured than the same disease elsewhere.

DR. KEYES's impression was that there might be something in Unna's idea. There was certainly a modification of syphilis in some cases, and this might be due to a seborrhœa; he, therefore, could not coincide with Dr. Taylor in regarding the idea as too much of a refinement.

DR. STURGIS failed to find anything in the case like a seborrhœa. We might see fatty scales in any fatty subject, and this might modify the syphilis, in the same way that an eczema might be said to do at times.

DR. ELLIOT would remind the gentlemen that Unna's seborrhœal eczema had nothing to do with the sebaceous glands, but was a catarrhal affection implicating the coiled glands, the upper part of the papillary portion of the cutis, and the rete. Dr. Unna states especially that the sebaceous glands are not the seat of the disease; he also regards the disease as parasitic, and had called the disease eczema seborrhoicum because the condition was a fatty one, and, probably not desiring to add another name to dermatology, had employed the well-known one of seborrhœa. Dr. Elliot would regard the name as appropriate since it expressed the pathological condition.

**Chancre of the Tonsil.**—DR. TAYLOR presented a case of this unusual location of the initial lesion of syphilis. The patient was a man who could not or would not give any cause for the disease. It first made its appearance on November 10, 1888. There was no lesion elsewhere. The well-marked adenopathies pointed to the tonsillar implication. The contagion probably took place in October, as these lesions do not give any sign of their presence for a week or ten days; then there will come difficulty in swallowing, and this is made worse by the large mass of ganglionic enlargements in the neck causing stiffness. By the end of November there was a roseola with general adenopathies; to-day there is a papular eruption on the chin and neck. When first seen, the lesion of the tonsil was brawny and bacon-like, and covered with a grayish pultaceous secretion. The diagnosis in these cases was made by exclusion, by the history of the case, acknowledgment of bad practices, the use of certain utensils, and the like; by the dysphagia, and by the pathognomonic glandular enlargement.

DR. BRONSON would ask Dr. Taylor what he would think of a case of a boy eight years old whose mother was under treatment with a syphilitic lesion on the lip. The child was presented to him with a roseola. He failed to find any initial lesion anywhere, but one tonsil was enlarged, though not ulcerated. There was also a thickening of the glands of the jaw on the same side. Was this a case of initial lesion of the tonsil?

DR. BULKLEY would diagnosticate the case as one of chancre of the tonsil. He had seen five cases. Dr. Bronson's case was probably one of initial lesion of the same region. In these cases there need not be much ulceration, but induration.

DR. SHERWELL agreed in the diagnosis of chancre. He had seen one case almost identical with this one, but larger.

DR. ALLEN said that we need not have much induration, and could make the diagnosis by exclusion. He had seen a case in a negro in which there was hardly any induration of the tonsil, but marked adenopathies. There was no lesion elsewhere. It was followed by secondary symptoms. In chancres of the septum nasi the diagnosis was made not so much by the appearance of the sore as by exclusion. He related a case of a man with a chancre in this region where the only history was that the man had a friend who had syphilis, with whom he was a good deal, smoking his pipe, etc. There was no history of his having put anything up his nose.

DR. STURGIS had seen four cases of chancre in this situation.

DR. FOX had seen a case with induration, and perfect history of having exposed himself.

DR. TAYLOR said, in closing, that he had put the patient on active treatment, and the lesion was much less marked than it was at first. When you get these cases well under mercury they rapidly soften. He would regard Dr. Bronson's case as one of these cases. He believed that many cases of *syphilis d'emblée* are those with initial lesions on the tonsil. After two months have elapsed it was hard to make a diagnosis. The chances are that any secondary affection of the tonsils within the first year would be bilateral. The matting of the glands under the jaw or along the anterior edge of the sterno-cleido-mastoid muscle was pathognomonic of the disease. He had seen a dozen cases.

DR. BULKLEY now called for the further history of Dr. Keyes's case of bullous syphilide, and of Dr. Fox's case of lichen in a child.

DR. KEYES had heard nothing further of his case, and DR. FOX reported that the eruption went entirely away without treatment.

DR. BRONSON reported the death of his case of melano-sarcoma. A post-mortem was not permitted. The disease had invaded the buccal cavity. Increasing doses of arsenic had had not the least effect.

DR. SHERWELL reported his case of sarcoma as doing well.

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## Correspondence.

### DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

**Lupus and Allied Diseases.**—Mr. Hutchinson's views on lupus are given in three lectures delivered to the Harveian Society.

He regards lupus as a family of diseases, of which common lupus is the head, other members of the family being several varieties of common lupus, to which distinct names are given; also lupus erythematosus with several varieties, and even, as probably allied "family forms," syccosis, rhinoscleroma, and "Kaposi's disease," or xeroderma pigmentosum.

The general definition of the "lupus family" is "serpiginous, infective scar-leaving inflammations of skin and mucous membrane." Lupus vulgaris and lupus erythematosus are thus distinguished :

#### *Lupus Vulgaris.*

- a.* Apple-jelly growth usually present.
- b.* Non-symmetry the rule.
- c.* Tendency to ulcerate.
- d.* Common in children.
- e.* Affects the two sexes almost equally.
- f.* Not closely allied to chilblains.
- g.* Very seldom fatal.

#### *Lupus Erythematosus.*

- a.* Apple-jelly growth little or none.
- b.* Symmetry the rule.
- c.* Non-tendency to ulcerate.
- d.* Not seen in childhood.
- e.* Far commoner in women than in men.
- f.* Closely allied to chilblains.
- g.* Sometimes fatal.

The principal forms of lupus vulgaris are struma-lupus (with subcutaneous abscesses and gland disease), typical common lupus, acne-lupus, eczema-lupus, psoriasis-lupus, nævus-lupus, and lupus lymphaticus, the five last being very rare. There are again eight clinical groups of the typical common lupus—viz.: 1, single patch; 2, multiple; 3, of hands and feet; 4, necrogenic; 5, of mucous membranes; 6, of septum nasi; 7, lupus mutilans; 8, lupus with elephantiasis.

Lupus erythematosus likewise furnishes two chief forms—viz., erythema-lupus (by the typical form) and seborrhœa-lupus (lupus sebaceus), besides certain rarer forms—chilblain-lupus, sunblain-lupus, acne-rosacea lupus, and psoriasis lupus, the two latter being very rare. Kaposi's disease is regarded as probably a family form of erythematous, not of common lupus.

Mr. Hutchinson does not, however, recognize any absolute distinction between the two main forms of lupus, since there are numerous connecting links, and cases often occur which can not be assigned exclusively to either. On this point his views will not meet with universal acceptance, and the compound double names used by the author have not passed into general use.

Some interesting remarks are made on multiple lupus. The secondary patches are generally near the primary one, forming in Hutchinson's words, "satellites." Sometimes they occur on distant parts of the body, when it is assumed that there is transference of infective material by the blood. The disease is more liable to occur on parts of the body exposed to cold.

The author's inference is, on the whole, against any connection between lupus and tuberculosis or scrofula. Lupus patients, as a rule, suffer from no other disease. Statistics, especially if derived from patients of the hospital class, are extremely fallacious, and almost any conclusion as to family history may be obtained by sufficient perseverance. In his own cases one set of lupus patients gave evidence of scrofula in only 28 per cent., and of such disease in near relatives in only 35 per cent. A later series of cases showed 9 per cent. with suspicion of phthisis, and 30 per cent. with enlarged glands, though in some of these the gland disease was secondary to the lupus. Notwithstanding these statistics, the author can not help believing that lupus is, in very many instances, a scrofulous disease, the tendency to this type of disease beginning in and remaining confined to the skin. He also thinks, in opposition to the general impression, that tuberculous antecedents are more frequent in cases of lupus erythematosus than in those of lupus vulgaris, and suggests that the discovery of the tubercle bacillus in the former, as in the latter form, is only a question of time.

Mr. Hutchinson's descriptions of the different forms to which he has given special names can hardly be reproduced in an abstract.

It will excite some surprise that he connects with lupus such diverse diseases as rhinoscleroma and the xeroderma pigmentosum of Kaposi. With regard to the former, Mr. Hutchinson thinks he has observed some transitional cases connecting it with lupus, and quotes descriptions by several observers, including the writer of this report, to show the histological likeness of the two. [As I am quoted, I may observe that I have found the structure of rhinoscleroma to be very much like that of lupus, but differing in the absence of giant-cells, and more strikingly in the characters of the bacilli, which are numerous in the rarer disease. Moreover, the geographical distribution of rhinoscleroma is enough to show its specific distinctness.]

[As to Kaposi's disease, it should be stated that the series of cases to which Mr. Hutchinson refers, fully described and diagnosed by Dr. Crocker, were first of all exhibited by another dermatologist at a London medical society as remarkable forms of lupus.]

Mr. Hutchinson's views differ widely from those generally accepted, either in this country or elsewhere, but, based as they are upon an immense experience and put forward by an observer of tried originality and power of observation, they deserve attention, which is more likely to be paid them when they are published in a separate form.—*Brit. Med. Journal*, 1888, i, pp. 9, 58, 113.

**Artificial Production of Lupus in Animals.**—Mr. Eve has been studying the effects of inoculation of lupus on animals. It is well known that miliary tuberculosis has been produced artificially in animals by the inoculation of portions of tissue or the cultivated bacilli derived from this disease; but no affection precisely resembling lupus has been hitherto obtained. Eve succeeded in two instances in producing lupoid ulceration of the ear in rabbits by inserting portions of the diseased tissue under the skin. A spreading ulcer covered with a dry scab formed, and similar ulcers developed at a distance from the primary one. Cicatrization took place after some weeks, and on killing the first animal no visceral lesions were found. Rabbits had been

inoculated from the other case, but only small, quickly healing ulcers or cold abscesses had been set up. Passing lupus, in one instance, through the guinea-pig, did not increase its virulence. The production of lupus as such in animals was, in the author's opinion, another point in favor of its being a modified tuberculosis of the skin. [It might perhaps be urged that the argument is a double-edged weapon, and capable of being turned in the other direction.]—*Brit. Med. Journal*, 1888, i, 644.

**Corns on the Palms in Psoriasis.**—In connection with Mr. Hutchinson's observations on the supposed effect of arsenic in producing corns on the palms of the hands of persons affected with psoriasis (see this *JOURNAL*, Sept., 1888, p. 344), it may be interesting to quote a case in which this occurred without any arsenic having been taken. Messrs. Fox and Ryle report the case of a butcher, aged fifty-two years, who had suffered from psoriasis for fourteen years but had never sought advice or been treated for it in any way. He was, however, concerned about a crop of small corns which had lately made their appearance, scattered indiscriminately over the palms and palmar surfaces of fingers and thumbs—in fact, a condition which seems precisely to correspond to that in Mr. Hutchinson's cases. The condition was not present on the soles of the feet.—*Brit. Med. Journal*, 1888, i, 74.

**Pemphigoid Eruption with Changes in Peripheral Nerves.**—Sangster and Mott reported to the Medical and Chirurgical Society the case of a woman aged seventy-eight who was admitted into Charing Cross Hospital in a very prostrate condition, a large extent of the surface of trunk and limbs being covered with a bullous eruption resembling pemphigus, of fairly symmetrical distribution. The temperature was 102° F. The patient was evidently suffering from renal disease; the urine was scanty and contained one third albumin. She died after nineteen days in hospital of uremia. The autopsy was made twelve hours after death, and showed granular contracted kidneys, the organs weighing two ounces and a half and three ounces. Portions of the external cutaneous nerve, of spinal ganglia, and of posterior roots were examined after hardening and showed parenchymatous degeneration of the nerve-fibers. The appearances seen were not such as could be explained by post-mortem changes. Both in clinical symptoms and in structural changes the case corresponded very closely with one reported by Leloir.—*Proceedings of the Medical and Chirurgical Society*, new series, vol. ii, p. 404; *Brit. Med. Journal*, 1888, i, 1273.

**Bromide-of-Potassium Eruption on a Suckling Infant to whose Mother the Drug was administered.**—A child, five months old, had on its face and scalp an eruption, consisting of vesicles varying in size from a hemp-seed to a sixpenny piece; the larger had a definite bright-red base, while a few, especially the older vesicles, were surmounted by brown crusts. The eruption suggested bromism, and on inquiry it was found that the child had taken no drugs whatever, but that the mother was epileptic, and had been taking bromide of potassium to the extent of thirty grains daily, with occasional intermissions, and was taking the drug when the eruption first appeared. Two ounces of her milk, after bromide had been taken for four or five days, were analyzed for bromine, with a negative result. The eruption slowly faded. The mother had also suffered from a pimply eruption, attributed by her doc-



tors to the bromide. The infant was shown to the Clinical Society by Dr. Shirley Murphy, who states that a similar case in a suckling child was recorded by the late Dr. Tilbury Fox in the "Lancet" for Nov. 7, 1874.—*Transactions of the Clinical Society*, 1888, vol. xxi, p. 293.

**Multiple Sarcomata of the Skin.**—Dr. William Robinson reports a case of this rare disease. The patient, an anæmic school-mistress, aged thirty-two, single, was unable to move from pain in the right hip, where an oval swelling four or five inches in length, was found attached to the upper and back part of the right ilium. It had existed six weeks, the skin was movable over it, and puncture with a trocar obtained no pus. There were also several nodules in the skin, face, and neck, and a few on the body, some of which projected half an inch above the skin level, varying in size from a split pea to a pigeon's egg. Some were evidently situated in the deeper layers of the skin itself, while over others the skin was movable. They were mostly isolated; some were firm, others elastic and compressible; over some the skin was of normal hue, over others white and glistening, while on other nodules it was bluish-black, giving the appearance of an enlarged vein. It was stated that the nodules developed shortly after the large tumor, and that some had disappeared, but there were no cicatrices. There was dysphagia, probably due to nodules in the submucosa of the gullet (as in one of Kaposi's cases). No sign of disease of any other internal organ. The nodules continued to increase in number up to the patient's death, three months and a half from the commencement of the illness, when no less than sixty or seventy were present on the head, neck, and trunk, the limbs being exempt. The lymphatics were unaffected. There was no microscopical examination of the growths.—*Brit. Med. Journal*, 1888, i, 793.

**Peppermint-Water in Pruritus Pudendi.**—Dr. Amand Routh recommends peppermint as a remedy in this affection, especially in the neurosial forms, when the cause can not be removed, and provided the skin be unbroken. The ordinary peppermint-water of the Pharmacopœia answers well, but is inconvenient from its bulk. A more concentrated lotion may be prepared by dissolving one drachm of borax in a pint of hot water, adding five drops of oleum menthæ piperitæ. It should be freely applied with a soft sponge. It is inapplicable if cracks, sores, or eczema are present.—*Brit. Med. Journal*, 1888, i, 793.

**Extractor for Comedones.**—Herbert Stowers describes two forms of extractor for comedones. One is a tube of the ordinary type, with the addition of a spring stylet inclosed in the barrel for the purpose of emptying the tube after use. The other consists of a very short tube (half an inch long), fixed at right angles to a handle by which it can be pressed upon the skin. This is better suited to the patient's own use before a mirror, as the tube, placed crosswise, allows of an unobstructed view.—Figure in *Brit. Med. Journal*, 1888, i, 1171.

**Myxœdema.**—As this affection is generally noticed in books on diseases of the skin, we may say that the committee appointed by the Clinical Society of London nearly five years ago has completed its report on the subject, which is of such length and importance that it will be issued as a separate volume. The final conclusions arrived at by the committee are as follows:

1. Myxœdema is a well-defined disease.
2. It affects women much more frequently than men, and the subjects are mostly of middle age.
3. Clinical and pathological observations, respectively, indicate in a decisive way that the one condition common to all these cases is a destructive change of the thyroid gland.
4. The commonest form of destructive change consists in the substitution of a delicate fibrous tissue for the proper glandular structure.
5. Interstitial development of fibrous tissue is also observed very frequently in the skin, and with much less frequency in the viscera, the appearances being suggestive of an irritative or inflammatory process.
6. Pathological observation, while showing cause for the changes in the skin observed during life, for falling of the hair and loss of the teeth, and for increased bulk of the body, as due to the excess of subcutaneous fat, affords no explanation of the affections of speech, movement, sensation, consciousness, and intellect, which form a large part of the symptoms of the disease.
7. Chemical examination of the comparatively few available cases fails to show the general existence of an excess of mucin in the tissues adequately corresponding to the amount recorded in the first observation [made on this point]; but this discrepancy may be partly attributed to the fact that the characteristic tumefaction of the integuments varies considerably throughout the disease, and often disappears shortly before death.
8. In experiments made on animals, particularly on monkeys, symptoms closely resembling those of myxœdema have followed complete removal of the thyroid gland, performed antiseptically and with, as far as could be ascertained, no injury to the adjacent nerves or to the trachea.
9. In such experimental cases a large excess of mucin has been found in the skin, fibrous tissues, blood, and salivary glands. In particular the parotid, normally containing no mucin, has contained it in quantity corresponding to that normally found in the submaxillary gland.
10. The results of the removal of the thyroid gland in man demonstrate, in an important proportion of cases, subsequent development of symptoms exactly corresponding with those of myxœdema.
11. In a considerable number of cases such symptoms have not been known to follow the operation, the apparent immunity being in many cases probably due to the presence and subsequent development of accessory thyroid glands, or to incomplete removal, or to insufficiently long observation of the patients after operation.
12. Injury to the trachea, atrophy of the trachea, injury of the recurrent laryngeal or cervical sympathetic nerves, and endemic influences have been supposed by various observers to be the true cause of operative or experimental myxœdema (*cachexia strumipriva*). But there is no evidence that any surgical operation performed on the neck and throat, except those in which the thyroid gland has been removed, has been followed by the symptoms under consideration. Also, in many of the operations on man, and in most or all of the experimental operations made by Professor Horsley on monkeys and other animals, no other parts were injured. Again, myxœdema has followed removal of the thyroid in persons not living in, or having lived in, the

localities of endemic cretinism. Hence it appears strongly proved that myxœdema is frequently produced by the removal, as well as by the pathological destruction, of the thyroid gland.

13. In the operative form of myxœdema no important difference is observed in the numbers of men and women respectively affected.

14. A general review of symptoms and pathology leads to the belief that the disease described as myxœdema, as observed in adults, is practically the same disease as that named sporadic cretinism as affecting children, that myxœdema is probably identical with cachexia strumipriva, and that a very close affinity exists between myxœdema and endemic cretinism.

15. While these several conditions appear in the main to depend on, or to be associated with, destruction or loss of function of the thyroid gland, the ultimate cause of such destruction or loss is at present not evident.

Dr. Ord was the chairman of the committee, and Dr. W. B. Hadden the honorary secretary. Dr. Cavafy, Dr. Halliburton, Mr. Victor Horsley, Dr. F. Semon, and others, were among the members.

**A Form of so-called Seborrhœa.**—H. G. Brooke, of Manchester, discusses the affection generally known to English dermatologists as *lichen circumscriptus*, seu *circinatus*, and called by Erasmus Wilson *lichen annulatus serpinginosus*, but now, in agreement with the American school, admitted by Liveing, Crocker, Colcott Fox, Jamieson, and others, as well as Brooke, to be a form of seborrhœa. In his historical sketch Brooke refers to a correspondence in the "Brit. Med. Journal," March, 1887, on a paper of Fox's, in which the present writer and Dr. Hyde, of Chicago, took part (see this JOURNAL, Jan., 1888, p. 33). Brooke gives a description of this affection as follows: The most typical expression is the appearance of small red maculæ and papules covered with more or less greasy scales, which spread by extension and agglomeration into patches and circles. The color is usually pinkish, dull red, or even brownish yellow, but the margin is often bounded by a characteristic bright-red line. The typical regions for its occurrence are over the sternum and between the scapulæ, but it is also seen on the limbs, where it is more often nummular than circinate, by preference on the flexor surfaces. On the hands and feet it affects the dorsum chiefly, though rarely also the palms and soles. The scalp is almost invariably involved, and here the disease assumes various forms; but Brooke's description is essentially the ordinary one of seborrhœa capitis.

It is often connected with acute eczema, but still Unna's name of *eczema seborrhoicum* is not a suitable one. Brooke thinks the affection requires a more distinct name than seborrhœa, and suggests *steatorrhœa* or *stearrhœa*. [But this has already been used by Liveing as being etymologically more correct in place of the name seborrhœa, which is a hybrid compound of Latin and Greek.] The differential diagnosis from psoriasis, eczema, and syphilis is given, and the possible parasitic origin of the disease is discussed. Brooke has often searched for vegetable parasites and found only micrococci. Cultivations have yielded nothing but "*streptococcus cereus*, *albus*, and *aureus*." In treatment, reliance must be placed on external remedies, such as mercurial ointments, preparations of sulphur, etc. Chrysarobin is effective but disagreeable.

In the above description Brooke purposely unites with *seborrhœa corporis* (*lichen circumscriptus*) the eruption usually known as *pityriasis rosea* (of Gilbert), also called *rosola furfuracea*, *circinata*, etc.; so that some features recorded belong to the latter affection. He holds that the two eruptions are manifestations of one and the same disease, the variations resulting from differences in distribution and idiosyncrasy. They can not be distinguished by the mere number of the lesions alone, a criterion on which he conceives Dr. Hyde to rely; nor by the wearing of flannel garments by the patient, an opinion which he attributes to the present writer. In this identification Brooke differs from most English and also, it would seem, from most American dermatologists.—*Medical Chronicle*, Manchester, March, 1888, vol. vii, p. 485.

[As I am often quoted in Dr. Brooke's paper, perhaps I may crave the indulgence of the editor to say a few words. I fully admit the sebaceous character of the so-called *lichen circumscriptus*, *circinaria*, or flannel rash, and think that in insisting on this point and removing the eruption from the group of lichen, the American dermatologists have rendered us an important service as regards this disease. The name *seborrhœa* only appears to me inadequate, since the affection is something more than hypersecretion. But this is not a fundamental point. I have never seen a well-marked case in which the patient has not worn warm underclothing, mostly flannel; and in the severer cases such has been worn day and night without changing. Probably for this reason it is commoner in men than in women. Occasionally eczema complicates the eruption, but if so it is always secondary. I have repeatedly examined scales for vegetable parasites, and have sometimes found scattered fungus spores and very generally micrococci, but certainly nothing distinctive. Cultivation has yielded several species, though not so many as Unna seems to have found; chiefly ordinary epiphytic micrococci of the skin, and more than one species of mold, but no bacilli. It is evident that the true parasite, if any, has not been found.

The distinction from *pityriasis rosea*, as to which I agree entirely with the description given by Dr. Nevins Hyde, appears to depend upon the following characters:

*Seborrhœa Corporis*.—1. Chiefly seen on the sternum and interscapular regions; sometimes to a small extent on the limbs.

2. The scales are greasy. On removing them, the red margin will often show hæmorrhagic points, as in psoriasis.

3. Very often associated with *seborrhœa capitis*.

4. Fostered by woolen underclothing.

5. Essentially chronic, lasting for months, or even with occasional intervals for years.

6. Occasionally passing into or producing eczema.

7. Easily cured by local means—viz.: change of clothing, thorough washing with soap and water, followed by a mercurial ointment, such as dilute unguentum citrinum. Cases complicated with eczema are more difficult of cure.

*Pityriasis Rosea* (*roseola circinata*).—1. Occurs as frequently on the limbs as on the trunk; may be very general.

2. Scales not greasy; no sign of hæmorrhage on their removal.
3. Not associated with seborrhœa capitis and probably not sebaceous at all, as shown by its occasional though rare occurrence on the palms where there are no sebaceous glands.
4. Not fostered by warm clothing.
5. An acute disease with a typical course, lasting from two to six weeks, sometimes longer.
6. Not passing into or producing eczema.
7. Singularly intractable by local remedies. It has even seemed to me sometimes that local treatment may aggravate the eruption.

The affection in its furfuraceous stage may resemble a scaly syphilide, and the distinction by objective characters alone might be difficult. But the totality of clinical characters (independent of history) will sufficiently distinguish it.]

J. F. PAYNE.

## Selections.

### Compound Gonorrhœal Infection.

BUMM, in prosecuting his studies upon the gonococcus, has discovered that infection by two distinct varieties of micro-organism can take place, the first preparing the way for the entry and development of the second.

Thus pyogenic microbes may enter one of Cowper's glands after the gonococcus has destroyed its glandular tissue and caused cystic degeneration, and produce suppuration. The mucous membrane of the bladder or urethral follicles may be affected by the staphylococcus in like manner, and the pelvic connective tissue may be invaded. Tubercular disease of the epididymis and tuberculosis of the Fallopian tubes have been known to follow closely upon a gonorrhœa, and are explained in the same way. In gonorrhœal rheumatism the micrococci found in the fluid of the joints are pyogenic, but why they should make their way to the articulations, and the gonococci not do so, is a question still unexplained.

Another source of error is the nodular lymphangitis of blennorrhagia. Small olive-formed tumors are produced along the course of the lymphatics as large as a cherry-stone or a small nut, and are firm, hard, and resistant. They arise insidiously upon the prepuce, but their seat of predilection is the glando-preputial groove, and when hidden by a phimosis are especially liable to cause an erroneous diagnosis. The diagnosis can, however, be made with almost certainty by the adenopathy when multiple indolent and long-lasting ganglionic enlargements are present.

These lymphatic nodules are essentially prone to resolution, but when they ulcerate, as they sometimes do, typical indurations characteristic of chancre are presented. Here the only element of diagnosis is found in the evolution of the disease. The indurated chancre never begins as a nodular lesion which opens like an abscess. The diagnosis of chancre should never

be made from the objective signs alone. The ecthyma of scabies may easily lead into error, resembling, when covered with a crust, the *chancre croûteux*; or when excoriated, red, and ulcerating, the ordinary chancre. The glands are often implicated in scabies, and the error of overlooking a chancre in a patient with lesions of scabies upon the genitals must be borne in mind. Treatment directed against the itch will soon make the diagnosis clear.

### The Antiseptic Treatment of Acute Gonorrhœa.

DU CASTLE gives his opinion of the antiseptic treatment of gonorrhœa in the following conclusions :

1. Antisepsis always has the result of maintaining the urethra in that state of asepsis which modern surgery seeks to obtain in all cavities which suppurate, as a condition favorable to the cure of the suppuration.

2. In a certain number of cases the antiseptic treatment brings about a remarkably rapid cure.

3. It is exceptional that when well done it does not bring about a more prompt subsidence of inflammation and a shorter duration of the acute stage.

4. It hastens the time when balsams can be used with success, and thus shortens the whole course of the disease.

5. Begun early, it diminishes the chances of extension of the blennorrhœa to the deep urethra, and makes vesical, prostatic, and testicular complications less frequent.

In exceptional cases he advises an attempt at abortive treatment by the injection of nitrate of silver.

As a non-irritating and effective antiseptic, resorcin is recommended. After the inflammatory stage is passed he employs balsamics alone or in conjunction with injections.—*Gaz. des hôpitaux*, Sept. 27, 1888.

### Stricture of Large Caliber.

IN an article upon the surgical significance of this condition ("Medical and Surgical Reporter," Dec. 15, 1888) Dr. J. W. White speaks of the intimate nerve connection of the urethra with all the viscera of the abdomen and pelvis, and with the walls of these cavities, and the reciprocal relations that exist between them. The increased friction and resistance resulting from even a slight fibrous peri-urethral deposit disturbs the normal relations of the bladder, causing irritation and frequent micturition, and the imperfect closure of the tube produces dribbling at the end of the act. Subacute inflammation accompanied with a catarrhal or muco-purulent discharge constitutes the resulting gleet, while pains in the lumbar and hypogastric regions are developed by reflex irritation. Just when a stricture becomes an active pathological factor is an unsettled point. No fixed caliber represents the normal condition of the urethra, and no special dimensions can be assigned to the canal as representing the precise dividing-line between health and disease. It has been conclusively shown that no more definite relation exists between the size of the meatus and the caliber of the urethra than between that of the mouth and the œsophagus, or the anus and the sigmoid flexure. The size of

the penis may be said in a general way only to furnish an indication of the urethral dimensions.

A number of observations are cited to illustrate the existence of natural irregularities in the urethra, even in the spongy portion, not distinguishable from coarctations of equal caliber due to incipient stricture. The possibility of resistance being due to spasm of the compressor urethrae muscle was eliminated by a series of experiments upon the cadaver, the instrument being arrested after death as well as in life.

Several cases are reported to show that a trifling difference in the circumference of instruments employed for dilatation, even as little as one millimetre, may result in a therapeutical effect far in excess of anticipations, and that we should not stop short of *full* dilatation.

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### Book Review.

*Psoriasis and Arthropathies.* By Dr. CH. BOURDILLON, Paris. In one volume of 260 pages in 8vo. Paris: Lecrosnier and Babé.

THE question of the close relationship between psoriasis and certain affections of the motor apparatus, especially of the joints and of their ligamentary appendages, has already been discussed in the writings of Gibert (1839), Cazenave (1847), and Devergie (1854). Bazin (1868) endeavored to clearly define the relation existing between these two morbid entities, and did not hesitate to refer them both to a common cause or diathesis—namely, arthritism. He admitted, as well, another form of psoriasis developing under the influence of a different diathesis—herpetism—and described a *psoriasis herpetica* and a *psoriasis arthritica*.

The collection of a great number of cases of psoriasis shows that affections of the joints are present in a certain percentage of cases. One observer even went so far as to write that of thirteen cases under his care at the moment of writing, ten had then, or had previously had, some trouble with their articulations varying from simple pain to general stiffening and uselessness of the joint. But Besnier, in a clinical lecture on the subject, says: "Patients suffering from psoriasis also present joint disease five times in a hundred patients"; and, in reference to a certain form of the affection: "Among arthropathies seen with psoriasis is found one in a hundred which has the characters of generalized deformations." In the thirty-six cases which the author reports, the disease occurred twenty-seven times in males. In twenty-nine cases the psoriasis was the first to appear; four times the cutaneous and the articular manifestations were synchronous, while twice the latter preceded the former.

In the generalized form of psoriatic arthropathies the joints generally first attacked are the metacarpo-phalangeal and the phalangeal, next the vertebral, the metatarso-phalangeal, the wrists, ankles, knees, etc. Although most of the joints may be affected, yet the lesions are generally more marked and

the pathological process more active in only a few of the articulations. Two features which tend to show the non-identity of these lesions with genuine rheumatic troubles are the fixity of the morbid phenomena and the absence of amelioration by the use of salicylic medication. Pain is usually the first articular symptom; the heat and redness are ordinarily moderate and are due rather to the eruption. The morbid process here finally leads to permanent deformity of the joints.

Patients presenting partial arthropathies in which only a few of the joints are affected can walk about and perform various kinds of work. In this form the larger articulations are oftener attacked than in the preceding form, as the knee, shoulder, or ankle, but generally the joints affected are those of the hand or foot. They may become deformed, and even permanently stiffened, by the formation of fibrous bands, osteophytes, and bony ankylosis.

In one case (a woman, aged thirty-three) the psoriasis degenerated into an exfoliative dermatitis, the skin becoming thickened, indurated, less sensitive, and desquamative, and the psoriatic patches becoming confluent on the flanks of the subject. In another case the psoriasis was inveterate and of very old date. It extended over the whole body, which offered a red, exfoliating surface of scarlatinous aspect.

In regard to the cause of the presence of arthropathies in psoriasis, the author considers in detail the rheumatismal diathesis, alcoholism, a possible poisoning from some extraneous source, interstitial nephritis and consequent insufficient elimination of uric acid, the influence of gonorrhœa and syphilis, parasitism, and, lastly, some lesion, dynamic or anatomic, of the central nervous system, especially of the gray substance of the spinal cord. He cites the researches of Hamilton and of Weir Mitchell of our own country, of Charcot, Brown-Séquard, Gombault, Déjérine, Pitres, and others, of France, who have produced facts tending to prove the nervous origin of these articular dys- trophies. It is this opinion which he adopts, and he adduces many arguments in its support. Even the microbic theory of Lang (1878), adopted by Wolf, of Strasburg (1884), and by Dematies, of Italy, in which the fungus called *epidermophyton* by Lang was held to be the active cause, is rejected here and the theory of the nervous origin upheld as being most in accordance with the clinical phenomena observed. As to the nature of the disease, it is believed to belong to the rather vaguely defined group of false rheumatisms, among which Professor Bouchard, of Paris, includes polyarthritides deformans or rheumatic arthritides, which is a result of malnutrition of the whole organism consequent upon poverty, cold, humidity, and misery of all kinds.

The treatment of myalgia, neuralgia, and melalgia accompanying psoriasis, and which consists in the employment of the bromides, opium, sodii salicyl., and antipyrine, is quite insufficient for the treatment of these arthropathies. These are also not usually ameliorated by the use of the salicylates, the alkaline remedies, the iodides, nor arsenic. Bromides and valerianates have produced some relief from spasmodic symptoms in these cases, but by far the most potent agent, in the author's opinion, which is based upon that of some of the masters of the school of St. Louis (Hôpital St. Louis, Paris), and upon personal observation, is the *prolonged tepid bath*. This is more certain, however, to relieve the subjective symptom, pain, than it is to remove



the objective lesions and deformities already existing and which are not easily cured by any means. The tepid bath should last from four to ten or twelve hours daily, the patient taking his meals while still in the bath. The temperature of the water should be kept at 90° to 95° F. during the whole time. Revulsion over the spine in the form of superficial application of the actual cautery in small spots (*points de feu*) aids much toward relief, and the usual regimen of psoriatic patients should be adhered to, as the suppression of the following aliments: pork, fish, cheese, pepper, fat, spirituous drinks, wine, alcohol, etc. This whole method of treatment is a rational one when the theory of the nervous origin of the morbid phenomena is once accepted.

SKINNER.

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### Books and Journals Received.

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Pathologie und Therapie der Alopecia areata. Von A. R. Robinson, M. B., L. R. C. P. and S., Edin. (Sonder-Abdruck aus "Monatshefte für praktische Dermatologie," vii. Band, 1888.)

The Operative Treatment of the Hypertrophied Prostate. By Francis Sedgwick Watson, M. D. Delivered before the American Association of Genito-Urinary Surgeons, Washington, D. C., September 19, 1888. Illustrated with Photogravures. Boston: Cupples & Hurd.

The Male Urethra: its Diseases and Reflexes. By Fessenden N. Otis, M. D. Detroit: George S. Davis.

Organisation de l'enseignement de la dermatologie et de la syphiligraphie dans les universités Allemandes et Austro-Hongroises. Par M. le Professeur Henri Leloir. Paris: G. Masson.

Estudio Clínico de los Tumores de la Vejiga. Por el Doctor Alejandro Settler. Madrid: Administracion de la Revista de Medicina y Cirugía Prácticas.

Eczema: its Treatment. By Albert E. Carrier, M. D., Detroit.

The History of the *Filaria Sanguinis Hominis*: its Discovery in the United States, and especially the Relationship of the Parasite to Chylocele of the *Tunica Vaginalis Testis*. By William M. Mastin, M. D., Mobile, Ala. [Reprinted from "Annals of Surgery."]

Retrojection in Gonorrhœa. By E. R. Palmer, M. D., Louisville, Ky. [Reprinted from the "New York Medical Journal," December 1, 1888.]

Jagttagelser over Enkelte Sjeldnere Hudsygdomme i Norge. Af Caesar Boeck. Kristiania: Det Steenske Bogtrykkeri, 1888.

The Radical Cure of Varicocele attended with Redundancy of Scrotum demonstrated by Time. By Morris H. Henry, M. A., M. D., LL. D. [Reprinted from the "Journal of the American Medical Association."]

Dermatological Notes. By James C. McGuire, A. M., M. D., Louisville, Ky.

De la dermatite herpétiforme de Duhring. Par le Docteur Brocq. Extrait des Annales de dermatologie et de syphiligraphie. Paris: G. Mason.

## Items.

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**Saint Bartholomew's Hospital and Dispensary.**—This institution was incorporated in December, 1888, for the free treatment of the diseases of the genito-urinary organs, both venereal and non-venereal, and of the skin. The president of the board of governors is Dr. George A. Peters. The members of the consulting staff are Drs. George H. Fox, Charles McBurney, and George A. Peters. The visiting surgeons on the genito-urinary service are Drs. C. T. Adams, E. B. Bronson, F. T. Brown, W. B. Clark, J. A. Fordyce, and F. J. Levisseur. The dermatologists are Drs. G. T. Jackson, P. A. Morrow, and C. C. Ransom. These names are well known to the medical public, and of themselves are sufficient to give character to the hospital. An excellent site has been found at 84 Carmine Street, and the dispensary will open for patients about the middle of January. The idea of a hospital of this sort is not new, but until now it has lacked encouragement from the public. While there is a great deal of medical advice given gratis to the people of this city, the large class of venereal diseases is recognized in but few of the dispensaries, and only in Charity Hospital is there any provision for their special care. That the institution is seen to be needed is shown by the interest the idea has awakened in some of the most representative men of the city, and we, as physicians, should recognize its value and give it our moral support.

**A New Method of destroying Tattoo-Marks.**—Dr. Variot has discovered a means of obliterating tattoo marks, a result hitherto reported to be difficult, and even impossible of achievement. He pours on the marked spot a concentrated solution of tannin, and works it into the skin by a series of pricks, just as in tattooing proper. A certain quantity of tannin is thus introduced beneath the skin. He then rubs the part with nitrate of silver, and allows the solution of the salt to remain *in situ* until the prick-marks show out as black points. The caustic is then wiped off, and the result is the formation of a black stain of tannate of silver. Inflammation is set up, and in the course of a fortnight scabs form, on the disappearance of which no trace is left of the original design, the only souvenir being a reddish scar, which in time becomes less visible. Various other plans have been tried without success—scarification, the introduction of opaque powders and caustics into the skin, etc. In no case did he have to deal with troublesome suppuration, although if the area be large it is well to do a piece at a time.—*Med. Press and Circular.*

**Eczema of the Eyelids.**—In chronic persistent eczema of the eyelids, which is not associated with a scrofulous constitution, Unna recommends a weak resorcin ointment. His formula is cold cream 10·00, resorcin 0·2, to be gently rubbed into the eyelids three or four times a day.

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## Editorial Note.

THE publishers of the journals with which we exchange will confer a favor on the editors of this JOURNAL by sending their publications to the care of D. Appleton and Company, 1, 3, and 5 Bond Street.

# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### THE QUESTION OF RELATIONSHIP BETWEEN LICHEN PLANUS (WILSON) AND LICHEN RUBER (HEBRA).\*

BY A. R. ROBINSON, M.B., L. R. C. P. AND S. EDIN.,

Professor of Dermatology in the New York Polyclinic ; Professor of Dermatology and Pathology in the  
Woman's Medical College of the New York Infirmary ; Member of the  
American Dermatological Association, etc.

(Concluded from page 57.)

**P**ROGNOSIS.—In all the well-established cases of this disease, as reported by Hebra and others, there was a marked tendency to a fatal termination by marasmus or some intercurrent disease caused indirectly by this condition. That the disease can in many cases be cured by the administration of arsenic in proper quantity in no wise modifies the statement that the tendency of lichen ruber is to extend over the whole cutaneous surface and finally prove fatal.

*Histology.*—On account of the rarity of this disease, very few observers have studied the anatomy of the lesions. Hebra ("Lehrbuch der Hautkrankheiten," erster Band, zweite Lieferung, 1874, p. 391) states that, no matter how red the skin appears before death, it is found on post-mortem not to be thickened, but only pale, flabby, devoid of fat-tissue, and covered with a greater or less amount of scales. Under the microscope the hair-follicles are seen to be funnel-shaped, with the apex of the funnel downward, while the papillæ and papillary blood-vessels are enlarged.

Neumann ("Lehrb. d. Hautkrankheiten," Wien, 1880, p. 308) found the corneous and rete layers increased in size, the interpapillary portions of the rete enlarged and showing growth downward into the corium.

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\* Read in part before the American Dermatological Association at the Congress of American Physicians and Surgeons in Washington, 1888.

The papillæ were partly sunken and atrophied, and partly, especially at the periphery of the papule, enlarged, and contained broad-meshed elastic fibers. The blood-vessels were enlarged, and cell infiltration, especially around the blood-vessels, was observed. The excretory duct and the orifice of the sweat-glands were dilated and filled with epidermic cells. The cells of the external root-sheath of the hair at the base of the hair-follicle were increased and formed conical projections into the surrounding tissue, giving the hair-follicle the appearance of an acinous gland. The root of the hair had a brush-like form. The muscles of the skin were hypertrophied.

As Neumann describes atrophied papules as being present, it is evident that he examined lesions of considerable duration, and not the most recent ones. Nevertheless, his description is not that of an inflammatory process such as we have found to exist in lichen planus; neither do the drawings accompanying the text show any round-cell collection beyond the perivascular region, and even there but little is to be observed. This author was among the first to study both lichen ruber and lichen planus, and he refuses to accept the view that they are identical diseases.

Biesiadecki ("Untersuchungen aus dem pathologisch-anatomischen Institut in Krakau," Wien, 1872) does not consider that the changes described by Neumann as occurring in the sheath of the hair-follicles are characteristic of the disease, or a necessary part of the process, as he found normal follicles within the area of the lichen papules. According to this observer, the central part of the papule consists of atrophied papillæ, containing dense connective tissue and narrow and empty blood-vessels. Similar changes are present in the upper part of the corium. In both there are no cell elements to be observed. The rete corresponding to this central part is also atrophied. In the peripheral portion of the papule the papillæ are longer and broader than normal, and the tissue œdematous. Here and there are a few cells which look like exudation or connective-tissue corpuscles. The blood-vessels are enlarged. Similar changes are present in the upper part of the corium. The rete is thickened, and small hemorrhages are sometimes found in the papillæ or in the rete. He also found colloid degeneration of the walls of the papillary blood-vessels.

Hans v. Hebra ("Die krankhaften Veraenderungen der Haut," Wien, 1884, p. 381), commenting upon the descriptions of Hebra, Hillier, Neumann, and Biesiadecki, considers that they show that the lesion depends upon changes in the epidermis, and that the so-called inflammatory symptoms are the result of a stasis in the capillaries. He regards the atrophy in the center as the result of pressure, as the blood-vessels are collapsed and empty. As hyperemia was present only in the peripheral part of the papule, and no other condition except a slight œdema was observed, there

eruption behind both internal malleoli, on the inner surface of the lower part of both thighs, on the volar surface of the wrist, and on the forehead. In about six months the lesions around the malleoli disappeared, but on the right hypochondrium there were two lentil-sized, bright-red, flat, shining papules, and similar ones were present on the forehead near the margin of the hair, and a single bright-red, hemp-sized flat papule on the back of the right hand. On the anterior and external side of the lower part of both thighs there were a few acuminate, milium-sized, bright-red, shining papules. On the apex of these there was generally a hair, and on the others a small epidermic plug, containing a rolled-up hair, could be scratched off. In this case, as above reported, I find no positive proof that the patient had a lichen planus, but, even if he had, the acuminate lesions were not those of lichen ruber, and were probably those of an eczema—a perifolliculitis pilorum.

As I can not accept the diagnosis of Unna's cases of lichen ruber as examples of the disease described by Hebra for reasons already given—and I am not aware that they have been accepted by any dermatologist—I need not analyze his reported cases of combination of acuminate with flat or obtuse lichen lesions.

If we continue our search among German authors for proof of a relationship or combination of the two forms of lesions, we do not find a single case reported which will stand any criticism—that is, that shows the existence of two forms of lesions upon the same person, and each form, if alone, having all the necessary characters for the diagnosis of lichen ruber or lichen planus, as the case might be. And yet, upon the evidence of such cases as I have just quoted, the belief seems to be almost universal among German dermatologists that lichen ruber and lichen planus are but two forms of the same disease. It is true that the original observers of the two forms, Hebra and Wilson, regarded them as similar diseases, but they never gave any reasons for their belief, and it is a question, I think, if Wilson ever saw a case of lichen ruber, or Hebra one of lichen planus which he recognized as such, when they gave their views on the relationship of these eruptions.

In France they do not know the lichen ruber of Hebra, as I believe no case has been, as yet, observed in that country; but Brocq (*"Sur le lichen ruber," "Annales de Dermat.,"* 1886, p. 389) states that a combination of lichen acuminatus and lichen planus is well recognized, and cites what he calls an excellent example of this combination from the thesis of Lavergne. As this case is referred to as especially proving a relationship between the two forms of eruption, I will quote the principal portions of it as given by Lavergne in the original (*"Thèse de Paris,"* 1883) thesis.

CASE VII of Thesis.—Patient aged fifty years, female. Nine years ago had a similar eruption to the present one, and was treated by arsenic and starch

baths. The treatment benefited her considerably, and later the eruption disappeared. Five months ago it reappeared as itching lesions about the size of a pin-head, and situated especially about the waist.

*Present Condition.*—The eruption, which is present over almost the whole body, does not present everywhere the same characters. The head is free. *Left hand:* The eruption only occupies the dorsal surface of the wrist, and consists of papules and macules. The papules are of a very pale red, almost yellow, are round, rough to the touch, of the size of a pin-head or of a grain of hemp, little or not at all itchy. They are isolated, nevertheless they tend to arrange themselves in circles, the center of which is occupied by the macules. On the dorsal surface of the right hand the papules present the same general characters. *Left forearm:* The eruption is specially marked on the anterior surface of the forearm. Some of the papules are isolated and others grouped. The isolated papules are flat, shining, of similar size to those on the wrist, yellowish, and slightly elevated above the general surface. In the center of some of them there is a small black point, which appears to be the obliterated orifice of a hair-follicle. The margins of the polygonal papules are in connection with the little furrows visible on the surface of the epidermis. There is, properly speaking, no desquamation. The isolated papules afterward form patches. The latter have a darker and redder color. They have an irregular form and itch very much. There is some desquamation, and the skin is slightly thickened. Only a few papules are present on the posterior surface of the forearm. *Right forearm:* The lesions present the same characters. They tend to arrange themselves in circles or half-circles. At the right elbow there are several isolated papules of a shining coppery color and larger than those already described. *Left arm:* The external surface is free. On the internal surface the papules are isolated, very numerous, very brilliant, itch greatly, and are disposed in lines following lesions produced by scratching. On the right arm the seat of the eruption is the same, and appears duller.

On the thorax, from the breasts, the eruption has no longer the same character. Here the papules are very numerous, as large as a pin-head, acuminate, *of the same color as the rest of the skin, and covered on the summit with a black point or a small whitish filament (sebaceous matter)*, giving to the touch the sensation of a series of closely seated and pointed rough objects. There is no itching and *no desquamation*. In the center of this eruption there are a few disseminated papules of lichen planus. Patient says that she was rubbed with croton oil four months ago. She had previously no eruption on the thorax. On the abdomen a few papules of both forms are present. Over the hips, the kidneys, and the sacral region the eruption is confluent. While over the hips only lichen-planus lesions exist, over the kidneys and sacral regions both forms are present. The papules, however, are browner and deeper in color, and drier and rougher. Itching feeling is here very active, especially during the night. *There is no desquamation or thickening of the skin.* On the right leg, along the ridge of the tibia, are almost coppered-colored patches, which have existed four to five years. Some of them are perfectly smooth, a little whitish in the center; others have an uneven surface. On the dorsal surface of the foot the little

are no grounds for the view that the process is an inflammatory one. He considers that the process commences in the epidermis, and that any changes in the papillæ or corium and their blood-vessels are secondary to the pressure from the epithelia either upon the general surface or within hair-follicles or other gland structures.

Obtulovitz ("Beitrag zur Pathologie und Therapie des Lichen ruber exudat."—ref. in "Vierteljahrsschr. für Dermat. u. Syph.," 1877, p. 259) describes the microscopical appearances in a person upon whom the eruption was very general. He did not find the hairs affected in the manner described by Neumann. The millet-sized papules were covered with epithelium, which did not color in carmine. Ecchymoses were not infrequent under the epidermis. On the apex of the lesion there was usually a depression corresponding to a dilated hair-follicle orifice and containing a hair. The epidermis was thicker in this depression than elsewhere. The papillæ beneath the depression were atrophied, but outside of this region they were, perhaps, somewhat enlarged. An occasional exudation corpuscle was present beneath the mucous layer, but there were no emigrated corpuscles. In the true cutis the blood-vessels were dilated and filled with corpuscles and surrounded by a seam of exudation corpuscles. In the larger papillæ the blood-vessels were dilated and surrounded by exudation corpuscles.

In this case it will be observed that Obtulovitz describes an old papule, as the central part was already atrophied, yet there were but few inflammatory changes, and there is no proof that they were not secondary to the changes in the epidermis.

Köbner ("Zür Pathologie des Lichen ruber," "Berl. klin. Wochenschr.," 1887, No. 20) describes briefly the anatomical changes present in the skin of a patient who already had the disease about two years. There was much perivascular cell infiltration about the superficial and the deep network of blood-vessels, and, although less, yet a general infiltration of round and spindle-shaped cells, especially of the latter, in the whole cutis, the infiltration being greater in the upper than in the lower part of this structure. The corneous layer was thickened; there was an abnormal cornification of the slightly thickened rete. The papillæ were partly atrophied, the sebaceous glands from four to five times their normal size, and in some places there were signs of hypertrophy of the hair root-sheaths, while in other places there was atrophy of the hair-follicles and falling out of the lanugo hairs. This observer preferred not to rely too much upon the appearances seen in the sections, as the case was one of unusual severity, and I think every one will agree that the study of such sections can not enable an observer to form any positive opinion as to the primary character of the anatomical changes.

The authors whom I have quoted include, I believe, all who have

studied microscopically the changes in the skin in undoubted cases of lichen ruber acuminatus, and a consideration of the anatomical changes described by them shows that there is no special relationship between these changes and those already described as taking place in lichen planus. Even admitting that inflammatory changes as described by some are present at the earliest period of the papule formation, it can not be compared in intensity with the inflammatory changes in lichen planus, and yet clinically the disease is regarded as a much more severe affection than lichen planus; but no one has shown that inflammatory changes are present in the earliest stage of formation of a papule, and no observer describes as existing at any stage of the eruption such changes as are present in lichen planus. In the sections figured by Biesiadecki not a single exudation corpuscle is to be seen, and the drawings by Neumann show the round-cell collection to be slight in amount and limited to the perivascular region. From a careful study of the description and drawings by the writers quoted, I must agree with Hans v. Hebra that the circulatory disturbance is secondary to the changes in the epidermis, and that, in consequence of a downward pressure by this structure, there is produced an atrophy of the papillæ and an exudation and emigration from the blood-vessels. I will refer directly to the difference in the mode of formation of the atrophy in lichen ruber and in lichen planus.

I have studied recent and old papules from an undoubted case of lichen ruber acuminatus—that is, the case presented all the characters described by Hebra, and has been diagnosticated as an undoubted example of the disease by the different dermatologists who have seen it. The form of the lesions, their manner of arising and spreading, the extent of the eruption, the structures invaded, and the tendency to a marasmic condition, left no doubt as to the nature of the disease. In Fig. 9 is shown a section of a recent papule under a low magnifying power. The section includes some normal skin at both ends, and represents a section through an entire papule. The corneous layer is greatly increased in thickness in the region of the papule, the thickness being greatest in the central part, and diminishes in amount as the periphery is approached. This layer presents an irregular undulating character, the most depressed parts corresponding to the situations of sweat-gland or hair-follicle orifices. The epithelia are not arranged in flattened lamellar plates, as was often observed in lichen planus, but have often a more or less polygonal shape, with a vertical diameter as great as the horizontal one. This arrangement and character of the epithelia are well shown in Fig. 10. The stratum lucidum is not distinct, and the granular layer is not increased in thickness. The rete mucosum is slightly increased in thickness in some places, but usually there was no change in this layer. In some places it extended upward to an abnormal extent, and in other places the inter-



papillary portion probably extended somewhat downward into the corium, as seen by comparing this layer within the papule area with the same structure at the sides of the section. The changes in the rete, however, are neither marked in amount nor general throughout the lesion, for, as a rule, this layer seems to be normal. The papillary blood-vessels are slightly dilated and a few emigrated corpuscles can be seen in the perivascular area. There is no appreciable œdema of the connective tissue from inflammatory serous transudation. Some of the papillæ appear longer than

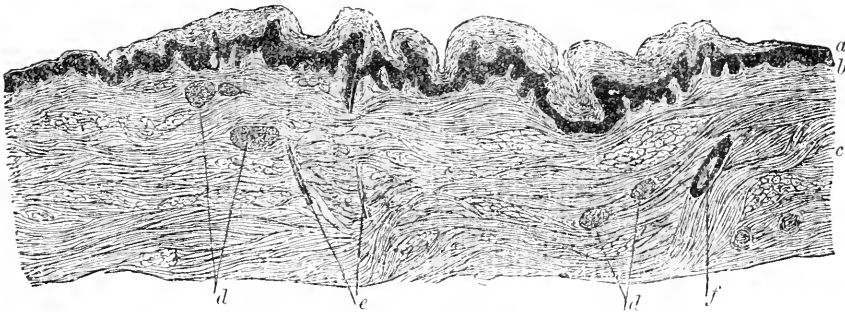


FIG. 9.—SECTION OF A RECENT PAPULE OF LICHEN RUBER.

*a*, corneous layer ; *b*, rete ; *c*, corium ; *d*, unstriped muscle-bundles ; *e*, sweat-duct ; *f*, hair-follicle.

normal from growth downward of the interpapillary rete. The corium is normal, except that there is slight dilatation of the blood-vessels and the presence of a few emigrated corpuscles in the perivascular area. The sweat-glands are normal, except that the orifice is dilated and filled with epithelia. The hair-follicles are unaffected, except at the orifice, where there is a large collection of corneous epithelia. The sebaceous glands appeared to be normal. The muscle-bundles are much hypertrophied.

The changes observed in the recent papule as here described point to the disease being an affection of the corneous layer of the epidermis—a parakeratosis and not an inflammatory affection of the corium. The amount of emigration and liquid transudation were altogether too little to justify the diagnosis of an inflammatory process.

In the older papules examined the condition showed a continuance of the process observed in the recent papules with consecutive degenerative changes leading to atrophy of the tissue. The corneous layer was much thicker than in recent papules, but the characters of its elements as regards shape, etc., were the same. Coloring with carmine showed a number of them, especially in the region of the orifices of the sweat-ducts and hair-follicles, to contain traces of a nucleus, granular or vesicular in character. The free surface was not provided with the dry, flat, squamous epithelia observed in normal epidermis. The rete mucosum was some-

what increased in size, and from its upper part sends projections toward the corneous layer. (See Fig. 10.)

This unevenness of the upper surface of this layer depends but slightly upon the rete mucosum itself, for it is to be noted that this layer

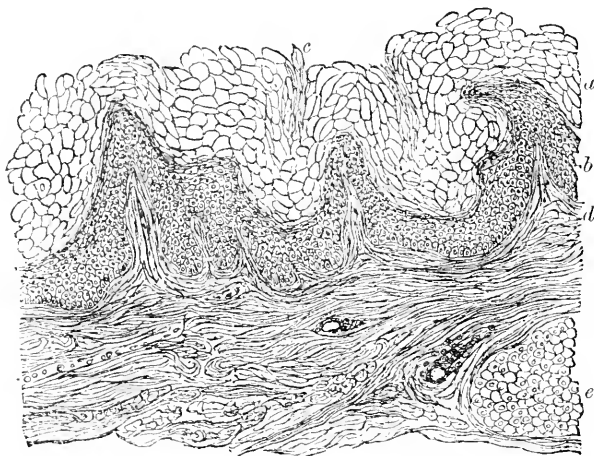


FIG. 10.—SECTION OF A PAPULE OF LICHEN RUBER WHICH HAD EXISTED SEVERAL WEEKS, MORE HIGHLY MAGNIFIED THAN IN FIG. 9.

*a*, corneous layer; *b*, rete mucosum; *c*, region of orifice of sweat-duct; *d*, corium; *e*, unstripped muscle-bundle (from the lumbar region).

is not specially increased in thickness where the projections exist. As the papillæ are not increased in size, at least to any marked extent, and the rete above them is not thicker than in other situations, it follows that the great unevenness of the upper part of the rete is produced by the hypertrophied corneous layer. This hypertrophy is greatest in the region of the orifices of the sweat-duct and hair-follicles, and there the corneous layer extends furthest downward. The rete-cells are not increased in size, and in many places are very small—a result, probably, of interference in their nutrition from pressure by the corneous layer. The granular and stratum-lucidum layers are not distinct. The interpapillary portions of the rete are increased in size in a few situations by growth downward into the corium, but this increase was never well marked. The changes in the form of the rete and in the form and thickness of the corneous layer are easily observed in Figs. 9, 10, and 11. In Figs. 9 and 11 it can be seen that the rete occupies a lower position in relation to the free surface than in the normal condition.

In the chronic lesions the cutis papillæ in the non-atrophied parts are not specially enlarged. The papillary blood-vessels are generally somewhat dilated, and a few emigrated corpuscles are present in the perivas-

cular area. Sometimes the number of emigrated corpuscles is considerable, but they are always collected in the immediate neighborhood of the blood-vessels, and are more abundant in the central portions of the lesion. Some of the papillæ are diminished in size by the downward pressure from the epidermis. The structure of the corium is normal, except in the blood-vessel area. The majority of the blood-vessels are dilated and surrounded by a variable number of emigrated corpuscles. This dilatation and emigration were much greater than in recent papules, but not more than would result from such changes as have been described as occurring in the epidermis. By comparing Fig. 11, in which this dilatation and emigration and normal intervascular tissue are shown, with Fig. 5, which represents the condition in chronic lichen planus, the difference in the anatomical changes is very striking. The condition in Fig. 11 can scarcely be considered as the result of a primary inflammation of the part. The unstripped muscle-bundles were always greatly hypertrophied. Some



FIG. 11.—SECTION OF AN OLD PAPULE OF LICHEN RUBER WITH ATROPHIED CENTER.

*a*, corneous layer; *b*, rete mucosum; *c*, corium; *d*, sweat-duct; *e*, atrophied part of papule; *f*, perivascular round-cell infiltration.

hairs showed hypertrophy of the external root-sheath, and others were normal. The sebaceous glands were well developed, but it is difficult to decide when such a structure is hypertrophied, as the normal size varies so greatly.

In old papules a retrograde process—an atrophy—often occurs, and it

is interesting to study the character of this atrophy and compare it with the changes which occur in lichen planus. In Fig. 11 is shown a section from an old papule in which an atrophic process was taking place.

The corneous layer of the atrophied part differed from that of the rest of the lesion in that the epithelia were flattened and arranged more in a lamellar form, and there was no sharp line of separation between this layer and the rete. The cells of the rete did not color so well in hæmatoxylin, and were frequently no longer united with each other, in consequence of which the sections often showed spaces devoid of cells in this layer, the cells perhaps having fallen out from the manipulations incident to preparing the sections. A peculiar condition was the adhesion of the first row of cells to the connective tissue of the papillæ, as seen in Fig. 11. Judging from the appearances of this layer, and the action of staining agents upon the elements, it was clear that the cells had undergone a simple atrophy. The papillæ were smaller than normal, and blood-vessels or exudation corpuscles could not be detected in the smallest ones. The corium directly beneath showed more "inflammatory" changes than in other parts of the lesion, as there was a considerable number of emigrated corpuscles in the perivascular region; nevertheless, the appearances did not suggest in any part a primary, active inflammatory process.

When atrophy occurs in a lesion of lichen planus it is the result of a fatty degeneration of the round-cell collection in the corium, just as it occurs in a papular syphilide. In many of the papules of lichen planus the round-cell infiltration is so dense and the inflammatory changes in the tissue are so great that the normal tissue of the part is destroyed; consequently, when the infiltrated cells undergo degeneration, an atrophy of the part results. When a lesion of lichen ruber undergoes atrophy the process, according to my sections as well as those of Biesiadecki, is one of simple atrophy from pressure, and affects primarily the rete and the papillary portions of the corium, so that the atrophic process in the two diseases is entirely different in aetiology, nature, and anatomical seat.

According to my observations, as above described, lichen-ruber lesions owe their origin primarily to changes taking place in the corneous layer, and are not due to an inflammatory process. In the recent papules I found but slightly dilated blood-vessels, and few if any emigrated corpuscles, while the corneous layer was greatly hypertrophied. It is true that in the older lesions there was more dilatation and more emigration present, but not more than would usually be present as a secondary condition to such changes as were found in the corneous layer. Dilated blood-vessels and the presence of emigrated corpuscles may denote an inflammatory process in the skin, but, unless this process is primary and not secondary to other pathological conditions, the lesions with which it occurs are not to be classed as inflammatory in origin. If the lesions of lichen ruber

were inflammatory in their origin, the changes in the corneous layer would require to be a secondary and resultant condition of the nutrition changes consequent on the inflammatory process. The microscopical examination, however, seems to show that the primary and principal changes occur in the corneous layer; that the other changes are slight in comparison, and evidently result from the former; and, furthermore, that such changes as occur in the corneous layer are never the result of an inflammation. An excessive production of corneous cells may, by pressure upon the rete epithelia, produce indirectly a thickening of this layer as occurs, for instance, in callositas. This continuous pressure upon the rete and underlying cutis—a pressure which increases in amount until the papule has reached its acme of development—is a sufficient and plausible explanation for the occurrence of the circulatory changes and atrophy in older papules.

The lesions of lichen ruber, then, are not inflammatory in origin, but arise as the result of a parakeratosis; there is a hypertrophy of the corneous layer from a continuous collection of epidermic cells, the result of an anomaly in the process of their production and casting off, and these cells by pressure upon the underlying tissues produce the changes occurring in the rete and corium. In lichen planus the lesions were considered to owe their origin to a circumscribed inflammation in the papillæ and upper part of the corium, and any changes in the rete or corneous layer to be secondary to the changed nutritive conditions the result of the inflammatory process. If the conclusions from my observations are correct, there is certainly no relationship between the factors producing the eruptions in lichen ruber and lichen planus.

*Treatment.*—Arsenic, when given in the proper amount, seems to have a decided and prompt action in this disease. Under this method of treatment the disease has lost some of the grave significance it formerly possessed, when twelve of the first fourteen cases reported by Hebra proved fatal. As far as known, it is the only remedy which seems to have a beneficial effect, although it is not probable that many methods of treatment have as yet been tried in this disease. That alkalies or the iodide of potassium would act as they sometimes do in lichen planus has not been shown.

From a study of the symptoms, form of the lesions, histology, prognosis, and results of certain methods of treatment, it is evident that there is almost absolutely no resemblance between the two forms of eruption described as lichen ruber and lichen planus.

In lichen ruber the papules are acuminate, covered with thin scales, itch but little, are not grouped, do not subsequently increase in size or even spread in a serpiginous-like form, and the eruption tends to extend over the whole cutaneous surface and to attack the hair structures and nails. The disease also tends to terminate fatally by producing a marasmic condition or some dependent intercurrent affection.

In lichen planus the lesions are usually flattish, shining, without scales, grouped, more or less angular in outline with a depressed central part, itch much, and show no tendency to become general over the body or to affect the hair or nail structures. The primary individual lesions also can, subsequent to their appearance, increase in size, and the eruption on certain parts of the body, especially upon the penis, may spread in a serpiginous manner, like in syphilis.

It has been maintained that the different anatomical situations of the lesions would account for differences in character of the two forms of eruption; but if the appearances of a patch of lichen planus which has invaded hair-follicles be studied and the absence of scales or acuminate lesions noted, and, further, if the lesions of the two diseases be studied upon the palms, it would be evident that this view has no good foundation.

Lichen planus has been also regarded as a mild form of lichen ruber—upon the ground, I suppose, that the one tends to a fatal termination, and that the other never affects the general health, the difference in the prognosis depending, perhaps, upon the mode of living in the different cases or upon the climate. That it can not be a matter of difference in intensity of the pathological process is shown not only by the difference in the nature of that process in the two forms of eruption, but also upon the benign character of the most extensive and acute cases of lichen planus. All microscopical observations show that the lesions of lichen planus owe their origin to an inflammatory process, while those of lichen ruber depend upon a parakeratosis. Later observations will show, I believe, a different aetiological factor, for the cause of the lesions will no doubt be learned ere long. That the difference in climate accounts for the difference in the gravity and character of the eruption was maintained when it was thought that lichen ruber did not occur outside of Germany; but since several cases have been seen in America, and all have shown the same characters and tendencies as those seen in Germany, that argument falls to the ground. But, even if it were true that the disease lichen ruber does not exist in a severe form outside of Vienna, any so-called mild form observed in other countries could represent only a less intense form of the same pathological process, and, as we have seen above, that can not be the case, as the primary process in the two forms of eruption is of a totally different nature. It is true that conditions of climate and mode of living do have an influence upon certain skin diseases, although not to the extent generally believed. Those who have seen lupus vulgaris in Vienna and in America must have observed the milder character of the disease in this country as a rule, depending probably upon the better diet of the laboring classes here and consequent better state of nutrition of the tissues invaded by the bacillus tuberculosis; but the difference in symptoms is only one of

degree; the situation, the appearance of the primary papules, the clinical symptoms to a great extent, the pathological histology and treatment, are the same, and even some of the cases here are as severe as any observed in Germany.

In the acute cases of lichen planus in which the eruption is more or less general it is strange that the disease shows no tendency to attack the hair or nail structures, or to endanger life, if the aetiology is the same as that of lichen ruber. Then there is the affection of the mucous membrane in lichen planus to be considered. In cutaneous diseases I think one expects that the mucous membrane, if it may be affected, suffers in the severer cases and escapes in the milder forms of the special disease; but here it is affected in lichen planus and not in lichen ruber. The same statement is true of the hair and nails as of the mucous membrane.

Those who have read Kaposi's recent paper on "*Impetigo Herpetiformis*" will remember what value he placed upon the character of the primary lesion and the course of the disease—that is, its tendency to a fatal termination; and I think these points should be fully as much considered and have as much weight in the question of relationship between lichen ruber and lichen planus.

Admitting, then, what scarcely admits of discussion or difference of opinion, that the clinical symptoms, prognosis, and histology of the two forms of eruption are entirely different, then they must also be considered as representing two different diseases unless it can be shown that the one form can change to the other, or that there is a tendency to a combination of the two forms upon the same person, or that in recurrences of the disease there is an exchange of form.

We all know the appearance sometimes presented by a psoriasis papule in consequence of sweating or washing having removed the scales from the lesion. The same thing may occur with a papule of lichen ruber, but that does not change it to a papule of lichen planus, even if it then resembles the latter more than an unchanged one of the former. Further, we have learned that what forms an elevated papule where the epidermis is thin does not produce the same form of lesion where this structure is thick, so that the presence of flat papules upon the palms and soles, in connection with acuminated lesions upon the rest of the body, does not show a combination of lichen ruber and lichen planus. Large lesions of that not infrequent disease lichen simplex (*eczema papulosum*) could easily be present in a case of lichen ruber and lead to error in diagnosis unless the life-duration and other characters of the lesion be studied, for we have already learned that these lesions are flattish and may be angular in outline and have a depressed center. Unless, therefore, in a case of undoubted lichen ruber, other lesions existed which corresponded in their symptoms and course—not a single lesion, but several—with the lesions of

ordinary lichen planus, a diagnosis of a combination of these two diseases should not be made. *Such a case has not yet been reported.*

We have seen that the lesions in lichen simplex (eczema papulosum) may resemble exactly those of lichen ruber, but the symptoms and course of the two diseases are entirely different; hence the presence of acuminate papular lesions covered with a thin scale does not alone justify the diagnosis of lichen ruber, and the presence of such lesions in association with the lesions of an undoubted case of lichen planus is no proof of a combination of the lesions of the two forms of eruption. The symptoms and course of the disease and of the eruption must be taken into consideration and given due weight in forming a diagnosis. Considering the rarity of lichen ruber, if a case of this disease was reported in which the characteristic eruption of both lichen ruber and lichen planus was present—not as regards form and color of lesions alone, but in all other respects—then the upholders of the view that the two forms of eruption have a similar ætiology—that is, that lichen ruber and lichen planus represent but two forms of the same disease—would have a strong argument in favor of their opinion. After a careful study of the literature of the subject, I do not find that such a case has been reported—that is, a case that will stand a careful analysis, subject to the above conditions as evidence of the character of the eruption.

I will not enter into a discussion of the division of lichen planus into *lichen planus proper* and *lichen obtusus*, and the association of the two forms of lesions upon the same subject as described by Unna, as no one doubts this association and dependence of the obtusus and planus lesions upon the same ætiological factor, although for reasons already given I can not consider that they represent two different varieties or forms of eruption—that is, that they require separate descriptions.

In denying the existence of proof of combination or relationship between lichen planus and lichen ruber in the cases reported by different observers as proof of such relationship, it is proper that I give evidence in support of my position and the reasons for not accepting the conclusions of those with whom I disagree. In criticising and refusing to accept the diagnosis of the cases hitherto reported as showing a combination of lichen ruber and lichen planus upon the same person at the same time, I rely upon the necessity of the presence of the conditions already described as positive proof of the existence of the one or the other form of disease, for I must maintain that a diagnosis can not always be made from the form of the lesions alone, even when a considerable number of them are present and situated on the usual regions for the disease, and certainly should not be made when the lesions are few and seated in unusual situations for that disease. The positive proof of identity of origin rests upon those who hold that view, for too many cases of pure uncomplicated lichen planus have



been observed and studied to justify the view that there is a *tendency* of this form to change to lichen ruber; and, although the number of reported cases of lichen ruber is still small, yet these cases have shown no *tendency* to change to lichen planus. If such a tendency exists in the case of either disease, surely it would have occurred many times in the great number of cases of lichen planus observed in America; but an undoubted case of such a change has not been reported.

The question seems to me to be no longer one as to whether there is a tendency to change from one form to the other form, but whether such a change or a combination of the two forms of disease has ever been observed; and yet if a solitary case of change or combination should occur, that could scarcely be accepted as proof of identity of origin, as such an occurrence could be an accidental one, just as we sometimes see eczema or syphilis or some other cutaneous disease in combination with lichen planus upon the same subject. The combination should be a more or less frequent one to justify the view of a probable similarity in origin.

A transformation of the individual lesions of lichen planus into those of lichen ruber and *vice versa*, with a corresponding transformed clinical history and course, would be convincing evidence of relationship; but I am not aware that any one has even thought that he has observed such a process. Although I say that such an observation would have much weight in the formation of an opinion in this instance, yet even such a case as transformation of lesions in some diseases does not of necessity prove similarity of origin. How often do we read of epithelioma developing from lupus vulgaris? Yet no one can maintain that the two diseases have aught in common either as regards the character of the morbid process or of the factors producing the anatomical changes; in fact, a transformation does not occur.

Thus we see what difficulties surround the question of relationship, and with such difference in the clinical symptoms and course of the two diseases, I doubt if any relationship would have ever been imagined if different terms had been employed by Wilson and Hebra to designate the eruptions. This similarity in nomenclature has been the cause of similar discussions regarding lupus vulgaris and lupus erythematosus, and parasitic and non-parasitic sycosis, as is now carried on concerning lichen ruber and lichen planus.

But to return to a criticism of the statements of the advocates of a relationship between lichen ruber and lichen planus. G. Behrend ("Lehrbuch der Hautkrankheiten," Berlin, 1883) says they often change the one into the other form, but the statement is simply an assertion, as he reports no cases and offers no proof. Kaposi ("Pathologie und Therapie der Hautkrankheiten") describes lichen ruber and lichen planus as two different forms of the same disease, and states they may occur in combination, but

he does not describe such a case. Boeck suggests that he has not described or reported such a case because it is such a frequent occurrence, and consequently it is only necessary to mention it without giving the proof. Boeck ("Einige Beobachtungen über Lichen ruber in Norwegen," "Monatsh. f. pr. Dermat.," 1886, No. 10) further states that the two forms are frequently seen in combination, especially in Austria and Germany. When we consider how few cases of lichen ruber of Hebra have been seen in Europe during the last few years—perhaps not ten cases in as many years—we can only wonder at such a statement. He reports two cases as showing such a combination, although he had seen but seven cases of lichen (he includes both forms together). The following is a condensed report of Case III of his article: "Male, aged thirty years. Eruption commenced ten years ago on both legs below the knee. At present there are on the external surface of the lower part of the thigh numerous large papules and patches, the majority of which are larger than a pea in size, and a few three to four centimetres in diameter. The papules and patches are of a bluish color, and, while the pea-sized papules are sharply limited and rather flattish on the surface, the patches are of irregular form, not sharply limited, and covered with a thick, rough, uneven corneous layer. The patches are considerably elevated, and the skin in this situation feels thicker and harder than normal, and a slight furfuraceous desquamation is present. At the periphery of the patches are a few very small, red, flat papules like the primary lesions of lichen planus. On the external surface of the lower part of the left thigh were a few characteristic flat papules; on the inner surface of the lower part of the left thigh there were a few pea-sized bluish patches. Finally, on the flexor surfaces of both forearms were ordinary papules of lichen planus. Fowler's solution was given for nine months, when the eruption on the arms disappeared, and that upon the legs was somewhat less. At the end of this period there appeared upon the back and abdomen a large number of isolated, small pin-head-sized, prominent, acuminate, red lesions situated at a hair-follicle orifice. Examined with a lens, the surface was *flat* and *shining*, and a hair could often be seen in the center, and around these could often be seen a few small epidermis scales. The youngest lesions are bright-red and prominent, the older ones brown-red and more sunken in. The outbreak was accompanied with pretty severe itching." A further description of this case is not necessary, as the above report is sufficient to show that the acuminate lesions were not those described by Hebra. Papules with a shining surface and devoid of scales are not the papules of lichen ruber.

In the other case (Case VII) the eruption commenced behind the right malleolus as a single flat papule. Later, other smaller papules formed around this one, and within a few months there was a symmetrical

lesions, few in number and disseminated, have the same color as tubercles of lupus. The patient *has a good appetite*, is not dyspeptic, the intestinal functions are normal. *The general condition is good.* The patient complains only of sleeplessness, caused, she says, by the itching. She remained in the hospital about three weeks, and was treated by three drops of Fowler's solution after each meal, and her condition upon leaving was as follows :

On the forearms the papules had partly disappeared. There was flattening of the papules on the breast, with *little or no consecutive pigmentation*. On the waist the lesions were disappearing. Over the tibia isolated papules could no longer be distinguished, but where they had existed the skin was deeply pigmented with a well-marked reddish brown.\*

While this patient had undoubtedly lichen planus, she certainly did not have lichen ruber, for the acuminate lesions present upon the breast bore no resemblance to the lesions of the disease lichen ruber. The lesions of lichen ruber have no black points upon the summit and no sebaceous matter, and are not of the color of the normal skin, but are red in color and covered with a scale—in a word, the lesions in this case should never have suggested the eruption described by Hebra. The report of this case shows how careful an observer should be in making statements as to the cause of objective characters. The small black point in the center of some of the papules is traced to an obliterated hair-follicle, although no sections were made to justify the assertion. Several of the earlier authors who wrote upon lichen planus state that a little depression corresponding to the orifice of a hair-follicle can be seen in the center of the flattened papules. Correct observation with the microscope has shown that the hair-follicle has nothing to do with the formation of the central depression of these lesions; but if it were the cause, the "guesser" would claim priority of observation. The simple statement that a central depression frequently exists is a safer form of description.

And so throughout the whole list of cases reported as showing an identity of ætiology there is not one that will stand analysis.

To show, however, how easily cases can be honestly reported as showing this identity of ætiology and yet be of more than doubtful value, I need but mention a case recently shown by Dr. G. H. Fox before the New York Dermatological Society. Two of the members of this society, who believe in a relationship between the two forms of lesion, maintained that both forms of disease were present, while all the other members denied that any lesions of lichen planus were present. The point, however, I wish to make is this, that if this case had been reported by one of the two gentlemen it would have been quoted as a proof of the relationship of the two forms of eruption.

Finally, in the experience of the members of the American Dermato-

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\* The Italics are my own in the above quotation.

logical Association, I am not aware that a single member has ever seen a case of lichen planus become changed to one of lichen ruber with all its symptoms and tendencies. This question was asked last year (1888) in Washington, and no member present had observed such a case, and it should be borne in mind that the combined experience includes the observation of probably several hundred cases of lichen planus. If such cases have not been observed, I must maintain that there exists no proof that the two forms of eruption depend upon the same aetiological factor—that is, that lichen ruber and lichen planus are but two forms of the same disease.

From the above argument and observations I would draw the following conclusions :

1. In doubtful cases lichen planus and lichen ruber are to be diagnosed, not by the form of lesion alone, but also by the whole symptoms and course of the eruption.

2. That lesions resembling in form those of lichen ruber and lichen planus exist in other diseases.

3. That Unna's division into lichen planus, lichen obtusus, and lichen acuminatus is an unnecessary if not an incorrect division.

4. That the cases reported by Unna were not examples of the disease described by Hebra.

5. That the same is true of the cases reported by Boeck and Lavergne.

6. That no cases have been reported which show absolutely, or even with probability, that lichen ruber and lichen planus are but two forms of the same disease.

7. If an identity of aetiology existed, such cases could have been reported, as lichen planus is a rather frequent disease.

8. Finally, in the absence of proof of a tendency to a combination of the two forms of eruption or to a transformation of the one form into the other form either as an eruption or of individual lesions, and, from the fact that the symptoms, course, prognosis, histology, and, to a certain extent at least, the effect of certain drugs upon the eruption are different, there appears to be no good ground for the view that there is any relationship between lichen ruber and lichen planus.

#### EXPLANATION OF THE COLORED DRAWINGS.

FIG. 1. CHRONIC LICHEN PLANUS OF THE LEG.—This patient, a male, had the scaly form upon the legs and the papular form upon the forearms. He was treated several months with arsenic. The eruption disappeared upon the arms, but that upon the legs was unaffected by the treatment.

FIG. 2. CHRONIC LICHEN PLANUS OF THE RIGHT KNEE REGION.—This patient, a female, was treated many months with arsenic, without benefit. There was some eruption upon the left leg, and many lesions around the waist.

FIG. 3. LICHEN PLANUS OF THE SCROTUM AND PENIS.—The eruption upon the scrotum had lasted eighteen years. He had lesions upon other parts of the body. The eruption upon the penis extended in a serpiginous manner as an infiltration without the formation of papules.

FIG. 4. CHRONIC LICHEN PLANUS OF THE ANKLE.—Same patient as Fig. 3. Figs. 3 and 4 show unusual forms of the disease. Fig. 3 should be viewed under an oblique light.

248 WEST FORTY-SECOND STREET.

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## REPORT ON AN UNUSUAL SPECIMEN OF URETHRAL CALCULUS, WITH OUTLINE OF HISTORY.\*

By HARVEY G. MUDD, M. D.,  
St. Louis.

I wish to present an unusual specimen of urethral calculus, with such outlines of the history of the case as I could obtain :

This specimen was obtained from a colored man, aged forty-eight years, hod-carrier.

He had more or less trouble in urinating for about five or six years. To use his own expression, his urine "would come good sometimes, and sometimes not." For five or six years past, when passing water in a full stream, the flow would sometimes stop suddenly and he would suffer excruciating pain. For perhaps about a year and a half before the operation he was compelled to pass water very often—perhaps every thirty minutes—and suffered constant and severe pain. He says that he had passed only a small stream for several years before the removal of the stone, and for some years he had been in the habit of passing a primitive instrument, much like a knitting-needle, into the urethra, hoping in this way to make it easier to pass his water.

About a year before the operation, on passing this instrument into the urethra, he struck something hard, which he thought was a bone ; he says it felt "like he was running the instrument into a lot of bones."

About six months before the operation his condition became such as to force him to quit work, and he took to his bed, not leaving it again until after recovery from the operation for the removal of the stones.

The man is very ignorant, and it was impossible to obtain a clear history of the beginning of the trouble, or of the time of descent of the stone into the urethra. It would seem certain that this took place more than a year before the operation, and more than six months before he took to his bed, as it was doubtless the stone he felt on passing the wire into the urethra at that time.

The large calculus (1) was found extending forward from the bulb. This portion was, of course, enormously dilated, the urine finding its way around

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\* Read before the Association of Genito-Urinary Surgeons at the Congress of American Physicians and Surgeons at Washington, 1888.

the sides of the stone. The stone measured three inches in circumference, two inches and a half in length, and weighed two hundred and eighty-one grains.

The small stones shown (2), with well-formed facets, were found in the membranous urethra. They were seven or eight in number, and together weighed eighty-two grains.

The single stone (3) lay by itself in the prostatic urethra.

A few small fragments were found loose in the bladder.

In one pocket in the bladder were found the stones (4) and a quantity of soft phosphatic material, and in a second pocket was found a large, soft stone, which broke up in removal.

The stone was removed by making a long incision in the median line, seizing the stone with forceps, and shelling it out with the finger. It was closely adherent in many places to the urethral mucous membrane, and required the exertion of considerable force for its removal. The fragments occupying the urethra posterior to the large stone were removed; then the urethra was dilated with the finger, and the stones were removed from the bladder without enlarging the outside wound.

The patient was suffering from septic fever when first seen the day before operation, and this fever continued for about a month after the removal of the stone. After the recovery from the septic condition was well begun, the patient's condition improved very rapidly, and he became quite stout.

There has been no recurrence of trouble.

Of interest in this case is the large size attained by the stone while lying in the urethra. Several fistulae had formed about the site.

No doubt the stone, while quite small, slipped into the urethra during an effort at micturition, became lodged where found, and grew gradually by deposition from the urine passing around it.

The site is quite unusual for so large a stone, most urethral calculi of any size being found in the prostatic urethra, becoming lodged at the neck of the bladder and pushing out gradually into the prostatic urethra, dilating the canal in their gradual growth. Ordinarily a calculus in the bulbous portion would early cause such obstruction as would demand operative interference.

Another point of interest is the formation of the two distinct pockets in the bladder, both filled with calculi.

One pocket was at the base of the bladder, a little to the left side; the other was well up toward the fundus. They were emptied, and washed out carefully.

How can we prevent reformation of stones in these pockets?

In a case operated on some months ago by Dr. H. H. Mudd, by the suprapubic method, a calculus was found in a pocket a little to the left of the central part of the base of the bladder, and had an exceedingly small opening connected with the bladder.

It was slit up by cutting the margin of the urethral side of the pocket,

hoping that the contraction in healing would leave a comparatively smooth surface. The border at the upper and outer margin was also cut.

In this case the man had been twice operated on for stone previously; once by rapid lithotripsy, once by lateral lithotomy, in both instances followed by a rapid recurrence of the calculus.

This man has had no recurrence of trouble since the suprapubic operation.

I think that, where the pockets are found at the base of the bladder, the margins may be snipped without danger. But where the pockets are found at the fundus, in the part covered by the peritonæum, the procedure would be quite risky and of very questionable propriety.

Where this pocket occurs on the anterior wall of the bladder, it would be safe to snip the margin rather high up, as the peritonæum covers only the upper part of the anterior wall.

Where found on the posterior wall of the bladder, it would be more difficult to deal with the pocket.

Another practical consideration is the question as to how one can best get at these pockets; through a perineal incision, or through a suprapubic cut.

The exploration of the pockets can, I believe, be made quite as thoroughly, and with perhaps more ease, and the operator would at the same time find himself in a position better enabling him to snip the margins if he makes use of the perineal section, than where the suprapubic operation is made.

I believe another advantage of the perineal operation, in dealing with these pockets, would be in the longer continued and more perfect drainage than is usual after the suprapubic operation.

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#### SUCTION OF THE URETERS.

By E. HURRY FENWICK, F. R. C. S. Eng.,

Surgeon (O. P.) to St. Peter's Hospital for Urinary Diseases; Assistant Surgeon to the London Hospital.

THE October number for 1888 of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES contains an article by Dr. Stein which I should not like to pass unchallenged. It was read before the Section of Genito-urinary Surgeons at the recent Congress, and in it Dr. Stein describes an instrument which he had had made for obtaining urine from either ureter by means of suction. In 1884 I had made for me a precisely similar instrument in principle, and almost so in construction, to the one which Dr. Stein proposes to use. It is described at length in the "Lancet" (London) for September 18, 1886, and the accompanying wood cuts (Figs. 1 and 2) will show at a glance its similarity to the picture

of Dr. Stein's instrument. Dr. Stein had never used the apparatus he describes, but mine, at the date of its publication, had been used not only

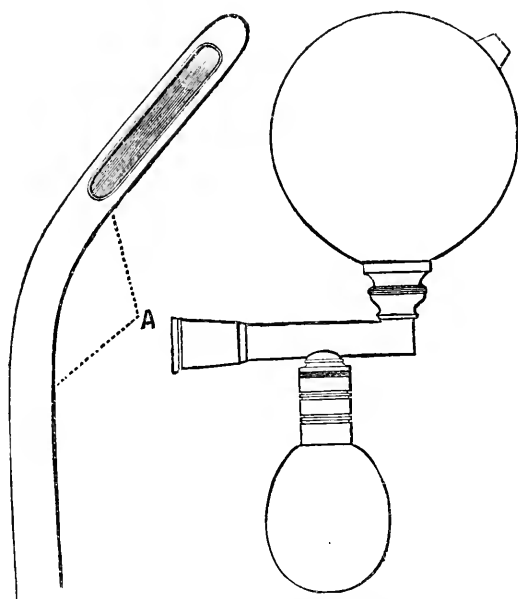


FIG. 1.—CATHETER ("URETER-ASPIRATOR") WITH LATERAL EYE FOR ENGAGING THE URETER, AND A DEFINITE ANGLE, A. SUCTION BALL AND URINE BOTTLE TO AFFIX TO OTHER END OF CATHETER.

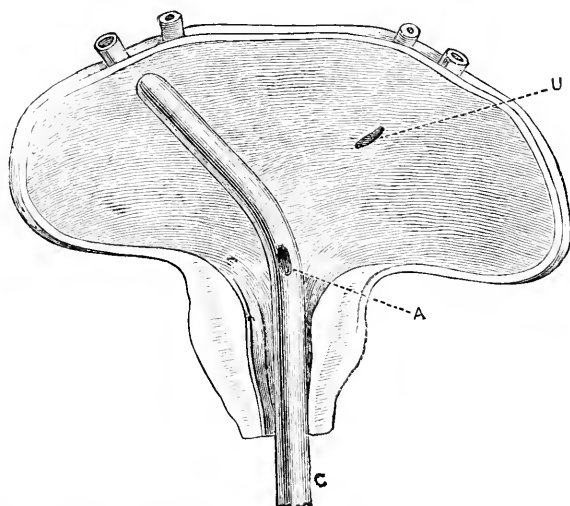


FIG. 2.—CATHETER ("URETER-ASPIRATOR") IN POSITION OVERLYING ORIFICE OF URETER.



to suck the urine from either ureter, but also to perform an operation for checking the bleeding from carcinomatous kidneys. This will be found in the "Lancet" (London) for 1887, under the heading of "Corkage of the Ureters," and in the "Transactions of the London Medical Society," under "Clottage of the Ureters" (vol. x, 1887, p. 276). My instrument is called the ureter-aspirator. I am sure Dr. Stein will at once acknowledge the priority of invention which I claim.

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 186TH REGULAR MEETING.

DR. KEYES, *President, in the Chair.*

**Case of Xanthelasma.**—DR. FOX presented a patient with this affection of eleven years' duration. It affected the eyelids of a man, and was remarkable on account of the dark color of part of the patch, which gave it the appearance of an ecchymosis.

DR. ALLEN said, in the discussion of the case, that he had seen quite a number of such cases, and that they often existed without being noticed by the patient.

DR. KEYES would ask if these growths did not always progress by continuity of tissue, and if they were cut out early, would it not stop their spread? He was of opinion that it would.

DR. ELLIOT asked Dr. Fox if he made any distinction between this and the ordinary form of xanthoma.

DR. FOX replied that he believed that they were the same thing, but that this case presented a reddish-purplish look which he had never seen. The disease existed most commonly in the form of small oval patches.

DR. SHERWELL said that he had excised a number of these lesions, and he believed that Dr. Keyes was quite right in his opinion.

DR. FOX would not think that excision would prevent the formation of new patches if there was a tendency that way. He had seen cases which had been cut out, but new lesions had developed in their neighborhood as isolated tumors. He would draw the attention of the society again to those cases of xanthoma that he believed he was the first to describe, in which the disease appeared upon the wrists and bends of the elbows in a striated form, and which might quite properly be called xanthoma striatum.

**A Case of Psoriasis.**—DR. FOX then presented a case of this affection which he had brought for the purpose of raising the question of eczema seborrhoicum. It was located on the scalp, extremities, scrotum and scrotal fold, penis, in both axillæ, and between the toes. The disease had lasted for twenty years, off and on, and had always been dry. It did not itch, except

on the scrotum. Some of the lesions were typical of psoriasis, and some were more yellowish and crusted than was usual in that disease.

In the discussion, DR. CUTLER said that he regarded the case as one of psoriasis, and the extra amount of crusting was probably due to the lesions having been irritated by applications or continued presence of moisture.

DR. ALLEN believed that the case was an atypical form of psoriasis, which had little of an eczematous element about it.

DR. ELLIOT believed that both psoriasis and eczema seborrhoicum were present. Psoriasis was not common in the axillæ. One of the diagnostic marks of seborrhoical eczema was that it did not occur in the usual localizations of psoriasis; but it did occur in the axillæ, upon the nose, on the perinæum, about the anus, and in the inguinal region. He would, for those reasons and from the symptoms present, regard the lesions in this case located in those regions as being those of seborrhoical eczema, while those on the extremities were those of psoriasis.

DR. BRONSON believed the case belonged to a group of cases that had often puzzled him, and which had led him to adopt the theory that psoriasis was not always an independent form of disease, but was a condition that might complicate or modify other cutaneous affections. Usually a person with psoriasis had the disease for life; but not infrequently the tendency was first developed at an advanced period of life, and sometimes as a complication of some other form of skin disease. In the present case the most important disease seemed to be psoriasis, but was associated with eczema. At some point, as in the axillæ, the trouble appeared to be solely eczema; in others the two affections seemed to coexist. Whether it was the eczema or the psoriasis that was the primary disease it was difficult to say. He had occasionally seen the two affections alternate at the same points. The psoriatic patch would become distinctly eczematous, and then, later, again psoriatic. Reference was made to a case recently seen, in which a syphilide apparently provoked the development of psoriasis. At the first moment psoriasis was the diagnosis made; but closer inspection showed that, in many places, the eruption was something more than an epidermidosis; that the desquamation was evidently secondary to an infiltrated disease in the corium, and the distribution and configuration of the patches were more characteristic of syphilis than of psoriasis. There were patches, however, especially on the arms, that were as typical of psoriasis as was possible. They were orbicular, some of them nummular, circumscribed, with no infiltration of border, coherent silvery scales, which, being scraped off, left a smooth, shiny, mucous layer with presently the bleeding points and apparent infiltrations beneath. Under internal treatment with protiodide, and locally the ammoniated mercury ointment, all the patches disappeared alike inside of a week, leaving nothing but pigment stains to mark the spots. In this case he believed that, in some way, a true psoriatic condition had been superinduced by syphilis.

DR. SHERWELL had long believed in the interdependence of diseases, at times, as the gentleman had just explained. He would diagnose the present case as one of psoriasis, while recognizing the eczematous condition.

DR. FOX said, in closing, that he thought the term eczema seborrhoicum had led to more confusion than it had helped to a better understanding

of the disease. We used to believe that there were three diseases : (1) eczema, which was moist ; (2) psoriasis, which was dry and scaly and tended to recur ; and (3) a disease that occurred on the sternum, and also on the scalp, in the form of circles, which were scaly. This we called seborrhœa, which perhaps was not a good name, but he would doubt if that of eczema seborrhoicum was any better. He believed that the present case was one of psoriasis with an eczematous tendency. The eczema accounted for the crusting. It is important for us to recognize the fact that psoriasis does not always have white, silvery scales. When it occurs in the axillæ or in the pubic region it naturally undergoes changes, in the same way that eczema has different appearances in different localities. It was desirable to recognize the fact that such modifications do take place, as it would often aid us in making a diagnosis. He would not admit a mixing of the two diseases.

DR. KLOTZ would suggest the possibility of uncleanness, and DR. BRONSON that of a mycotic element in the modification of the psoriasis.

**A Case for Diagnosis.**—Presented by DR. CUTLER. The lesion was located on the face of a man thirty-five years of age. It had existed for six years, and had been preceded by a mole. Matter formed in it from time to time, which was squeezed out, each time the growth growing larger and then again diminishing in size. It now presented a small ulceration.

DR. ALLEN did not see any of the characteristics of epithelioma, though the history and the location of the growth were right for it. Any way, he would cut it out.

DR. ELLIOT would diagnosticate it as belonging to the superficial variety of epithelioma.

DR. FOX regarded it as a superficial epithelioma, and believed that if it were not destroyed it would gradually extend and involve the eyelid.

DR. SHERWOOD agreed in Dr. Fox's diagnosis. He would scrape out the growth, apply a caustic, and let it suppurate out.

DR. KEYES would punch it out with one of his punches, and would expect to see it heal with a linear scar within four days.

DR. FOX would prefer scraping it with a curette and applying pyrogallie acid in ointment, which he thought would leave an even less noticeable scar than the curette.

DR. KEYES preferred chloride of zinc as a caustic.

DR. CUTLER said that he had made the diagnosis of epithelioma, but did not think the history was fitting.

DR. BRONSON, on behalf of the executive committee, then read a candidate's thesis, entitled "The Bacillus of Syphilis."

DR. KLOTZ reported that the case of circinate syphilis shown at the last meeting of the society was getting well on internal treatment alone, so that if there were any seborrhœal element in the case it must have been small.

DR. SHERWELL reported that the case of papillomatous growth on the back of the hand that he had shown at the last meeting was improving under mercurial treatment.

DR. ROBINSON reported that the case of erythematous lupus of the scalp that he had had before the society several times was not doing well, the disease having invaded the ear and appeared upon the tympanum.

DR. FOX mentioned having seen a case of erythematous lupus attended with ulceration of the soft palate.

DR. KEYES mentioned in this connection a case that he had had that looked very much like erythematous lupus of the face, the skin of the forehead being infiltrated, smooth, and without papillation. There was no history of syphilis, but still he suspected it, and put the patient on mixed treatment. She did not bear it well, and therefore, at other hands, underwent surgical treatment for a long time as a case of lupus, by scraping and caustics, the disease all the time making slow advance and invading the scalp. After about a year she returned to him, and he found a fungoid ulceration of the soft palate, evidently of specific nature. She was rapidly cured by the use of potassium iodide, and the scalp then recovered entirely.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**Contagiousness and Prophylaxis of Impetigo.**—For a long time it has been known at the St. Louis Hospital in Paris that true impetigo, characterized by an eruption of vesico-pustules whose contents tend more and more to grow turbid and then to become converted into yellow crusts, is an auto-inoculable disease upon the subject attacked and inoculable upon other subjects. In other terms, that it is contagious. The inoculation experiments instituted by Dr. Vidal nearly twelve years ago have left no doubt upon this subject. These notions of the affection have, however, not yet penetrated to the medical public at large, and it is this which has brought forth several recent works upon the subject. In a report addressed to the Council of Hygiene of the Seine, Dr. Ollivier cites quite a large number of instances of healthy children belonging to healthy families who have contracted impetigo in schools or in institutions where there were already to be found children having the same affection. Certain ones of these have thus created little foci of contagion in their families. We should, then, henceforth consider impetigo as contagious and inoculable. Pale, weak, and ill-nourished children whose skins are imperfectly cleansed offer a higher degree of receptivity than others. Mineral or organic particles and epidermic *débris* are causes of pruritus and exulceration of a mechanical nature which facilitate inoculation, and, besides, the skin of children is very fine. The author, therefore, thinks that children attacked with impetigo should come under the fourteenth article of the regulations of the prefectural instruction enacted at Paris on Dec. 15, 1883, which says that children in whom the medical inspector during his visit shall have noted symptoms of a contagious affection shall be at once sent to their parents with a letter of advice indicating the motive of the suspension. They shall not be again taken back until they have presented themselves at the medical consultation of the inspector, and received from him a certificate stating that readmission can take place without danger.

Measures of temporary exclusion could be dispensed with in cases where the eruption occupied a portion of the body which could be covered with suitable dressings, as, for instance, the scalp. In an article which appeared upon this subject in the "*Gazette hebdomadaire*," Dr. Eloy, after having himself also advised the same measures proposed by Dr. Ollivier, insists upon the necessity of exacting from each child the most minute care as to cleanliness, frequent baths with soap and water, and a slightly antiseptic wash for the hands and face each morning as soon as he has arrived at the school. He further recommends the proscription, in the family where children are attacked with impetigo, of the use in common of such articles of toilet as brushes, combs, etc. It is well to keep the regions on which the eruption is present constantly covered. Dr. Eloy recalls the fact that antiparasitic treatment has at all times been the most successful plan. He recommends that the crusts be made to fall by applying compresses of tarlatan covered over with a layer of mackintosh, and wet with elder-flower water, mixed with equal parts either of one-to-fifty boric-acid solution, one-to-twenty phenic acid, or one-to-five-hundred corrosive sublimate. (For my part, I find the last two solutions too strong, and I prefer to employ the boric solution, which is quite sufficient, and can not cause, like the others, active cutaneous irritation when applied upon surfaces already somewhat inflamed.) When the crusts have fallen (they can also be detached by directing sprays upon them or applying poultices of potato-flour made with boric-acid solution), an antiseptic dressing must be applied to the raw surfaces. For this purpose we can follow Besnier and apply an ointment composed of five grammes of Vigo ointment to a gramme of boric acid and thirty grammes of vaseline. This is spread upon fine linen and applied like a plaster. Dr. Vidal uses his "red plaster," which is an excellent preparation for impetigo, ecthyma, superficial dermic ulcerations, folliculitis, etc. Although I have already several times given the formula, I will repeat it:

R Minium.....	gram. 2'50;
Cinnabar. ....	" 1'50;
Emplast. diachyli.....	" 26'00.

This is to be spread upon fine linen in such a way as to make a sort of adhesive plaster, which is then cut into pieces of the size of the lesions to be covered. It is to be changed, according to the abundance of the suppuration, every twelve to twenty-four hours. Upon its removal the diseased regions are to be washed with a one-to-fifty boric solution and a new piece of the plaster applied, and so on until completely cured. When the impetigo is inflamed and the integument red and irritated, it is preferable to make use of ointments, and especially boric-acid ointment of ten per cent. strength, or one to seven. We can also with great advantage employ mercurial preparations. Calomel ointment gives excellent results. I think it preferable, however, to use a yellow precipitate ointment, one to fifty, one to forty, or even one to twenty, if the patient can stand it. Dr. Vidal has associated oil of cade with the yellow precipitate, with good results in the following formula :

R Hydrarg. oxid. flav.....	gram. 0'50—1;
Olei cadini .....	" 1'00—3;
Cerat. simp.....	" 20'00.

**Treatment of Local Asphyxia of the Extremities by Preparations of Quinine.**—In 1879 Vulpian had already proposed to treat symmetrical asphyxia of the lower extremities by sulphate of quinine in large doses. Dr. Siégeais has taken up this method again and has obtained some success with it, especially in the case of a young woman of twenty-one years of age, who was taken with violent pains in the legs and toes. During the attack the limbs were pale, cold as marble, covered with an abundant perspiration, and ecchymotic spots appeared upon the plantar surface of the great toes; the sensibility of the parts implicated was lessened. The patient was put upon a daily dose of one gramme of quinine, divided into four powders, and continued for three days, followed by an interval of three days, when it was begun again, and so on. After the sixth day of the administration of quinine she was able to walk a long distance on foot, so slight were the pains. The hyperidrosis of the feet, the pallor, frambœsia-like patches, and ecchymoses of the lower extremities had disappeared. The cure was definite and lasting after a month's treatment—that is to say, after the ingestion of fifteen grammes of sulphate of quinine. Vulpian gave as much as a gramme and a half per day. The author attributes these remarkable effects from this drug, first, to its sedative reflex properties acting upon the hyperæsthetic dorso-lumbar portion of the spinal cord which incloses the sciatic vaso-motor center, and secondly to its paralyzing vaso-motor action, of which the result is to destroy the vascular tetanus, which, according to his belief, constitutes in reality local symmetrical asphyxia of the extremities, or Raynaud's disease. When the local asphyxia is conjoined with lesions of constitutional arterio-sclerosis, the sulphate of quinine does not succeed.

**A New Procedure for Destroying Tattoo-Marks.**—It is well known how difficult it is to destroy tattoo-marks, which are at times so annoying to the unfortunate ones who have been foolish enough in a thoughtless moment to allow their bodies to be covered with designs often more or less obscene. Dr. Variot has just indicated a new procedure, after a number of experiments which he has carried out at the Central Infirmary of the Paris prisons. He pours at first upon the portions of the tattooed skin a concentrated solution of tannin; then, with the aid of a bunch of needles like those employed by the tattooers, he makes close punctures over the whole surface of the discolored skin. He then passes a stick of nitrate of silver with considerable pressure and friction over the whole surface upon which he has operated and pricked in the tannin. He allows the concentrated solution of the silver salt to act for a few instants upon the epidermis and the derma until the pricked points become of a dark or black color. He then wipes off the skin, and the surface is found to have become black from the formation of a tannate of silver which is produced in the superficial layers of the skin. In the first two days which succeed the cauterization there is a slight inflammatory reaction, with a variable amount of pain. In the two following days all parts which have had the tannin pricked in and the nitrate of silver subsequently applied take on a deep-black tint, forming a sort of crust, or eschar, which is thin but quite adherent to the deeper parts. On the third or fourth day after the operation the crusts are wholly painless. If, however, the tattoo has been extensive, the movements of the parts may become painful. At times a little

suppuration takes place beneath the crust, but there is never a great degree of inflammatory reaction. . . . In from twelve to eighteen days the crust, or superficial eschar, becomes detached spontaneously, the derma and epidermis have become repaired beneath it, and there is seen in place of the tattoo which has fallen with the crust a superficial red cicatrix which becomes progressively decolorized, and two months after the operation is but very little noticeable. Dr. Variot has employed without success fly-blisters; the red-hot iron, which may leave disfiguring cicatrices; tattooing with white substances, such as powders of enamel, pricking in milk, phenic acid, and tincture of cantharides. He has used tannin alone, acetic acid, the acid oxalate of potassium, and the ten-per-cent. solution of nitrate of silver—all to no purpose. The author thinks that his procedure could be employed with advantage in natural pigmentary spots and in congenital nævi more or less extensive and more or less deforming. Apropos of Dr. Variot's communication to the Society of Biology, Dr. Dupuy said that in the islands of the Indian Archipelago they cause tattoo-marks in Europeans to disappear by practicing a new tattooing with the juice of the *Carica papaya*. The operation leaves no cicatrix, and takes away red tattoo-marks as well as the blue ones.

**On Blennorrhagia and its Treatment.**—In France, as in all the countries of the world, works on blennorrhagia are most numerous, and new ones are constantly appearing. We will restrict ourselves to a brief *résumé* of the more recent and more important researches. Dr. Besnier believes that blennorrhagia is a general disease whose effects may be seen at various points of the organism, in particular upon serous surfaces, in articulations, in tendinous sheaths, in the muscular system, in the nervous system, etc. He also believes that we should institute against the disease a general treatment. He has endeavored, according to this idea of the disease, to give to his patients with blennorrhagia twenty grammes of Van Swieten's solution in a quart of milk each day, and this is the more beneficial as the mercury is eliminated by the kidneys. As local means, he recommends to the patient to urinate as seldom as possible—every four hours only, if he can; then, after micturition, to make slowly an injection of a half-syringeful of the following:

R Mucil. acac.....	gram. 250 ;
Bism. subnit .....	" 25 ;
Liq. Van Swieten.....	" 5 ;
Laudanum de Sydenham .....	" 1.

Shake before using. It is important to leave a deposit of subnitrate of bismuth as long as possible in contact with the walls of the canal, so urination should be postponed as long as possible after the injection—Dr. Besnier says four hours after. A new injection is then taken, and so on. Dr. Critzman has made some observations under the direction of Dr. Vidal upon the action of naphthol in urethral discharges. This substance exerts no influence upon the microbe of blennorrhagia, but, on the contrary, it has real antiseptic properties so far as the micro-organisms of suppuration are concerned; therefore he does not advise it in true gonorrhœa, but it is found very useful in simple urethritis, in balanitis, and in all the suppurative non-specific affections of the genital organs. According to Dr. Du Castel, resorcin is the most inoffensive and the best tolerated of all antiseptics so far recommended for blennor-

rhagia. His conclusions are based upon three years' observations at the Hôpital du Midi of Paris. He has found injections with resorcin completely painless, and it is altogether exceptional that he has heard patients complain in making them. Out of the hundreds of patients whom he has treated by this method he has been obliged to cease the injections in only a small number. In any case there is no comparison to be made in this respect between resorcin and the other antiseptics, which all have much more irritating properties. If we are dealing with a patient who has begun by carrying out the treatment called antiphlogistic—that is to say, one who has for a time used baths and mild drinks—the results are sometimes astonishing. Following the injections of resorcin, the pains become much less, the discharge decreases, is more mucoid, and may disappear definitely in a few days under the influence of these injections alone. The cure is at any rate sensibly accelerated.

If the patient has reached only the second or third day of his disease, the favorable results will be habitually very marked. The discharge remains very slight, the pains are not severe, and often after ten or fifteen days of treatment inflammatory phenomena are so slight that a treatment by balsams can be instituted. If, on the contrary, injections are begun about the eighth day of the disease, we obtain little or no good effect. It appears that resorcin does not act in a marked degree upon the gonococcus excepting as the latter begins to develop or when it approaches its decline after having run through the principal phases of its existence. Nothing is then more variable than the effects produced by this drug according to the period in which it is employed.

If after some days of injection the patient has no longer any pain, redness of the mucous membrane, or moisture of the canal, it is only necessary to advise that the injections be continued for some days more to obtain a radical cure. If the discharge, without being totally suppressed, has become so slight that there is only a little humidity of the canal, balsamics must be prescribed to be taken at the same time that injections are being continued. If the discharge is much less abundant, of a mucous nature or viscid, and has a gummy appearance, and if the mucous membrane is not at all irritated, balsamics must also be begun. If the mucous membrane, on the contrary, is red and tumefied, we must wait until the inflammatory symptoms have wholly subsided before administering the balsams and content ourselves with persisting in the resorcin injections.

The same course must be pursued so long as the urethral discharge remains purulent. At times it may be well to substitute astringent injections for those of resorcin. According to Dr. Lavaux, the best treatment for acute blennorrhagia consists in methodical washings of the urethra with a solution of nitrate of silver. For this procedure he introduces a double urethral catheter as far as the *cul-de-sac* of the bulb, and begins by washing out the anterior urethra with a saturated solution of boric acid. The introduction of the double catheter is but slightly painful. The solution of nitrate of silver in the strength decided upon is then passed for two or three minutes at the most, and this is followed by a free douching with the boric solution, which he repeats six or eight hours later. It is only at the end of twenty-four hours that he renews the washing of the urethra with the nitrate of silver. A one-



to-fifty solution is the strongest which he employs, and more frequently he uses only one to a hundred, or even one to two hundred. He chooses the stronger solutions the more acute is the blennorrhagia, and then decreases the strength gradually. At the end of four days the purulent secretion has usually disappeared and there remains only a slight whitish discharge, which either disappears spontaneously or with the aid of cubebis or local astringents. He obtains these results even when the blennorrhagia is at its full period of inflammation. In a case in which the gonococci of Neisser dated from only forty-eight hours, a single washing with nitrate of silver, one to a hundred, was sufficient to effect a complete cure. At times, on the other hand, a much longer course of treatment is required. The author has never had any disagreeable effects from this method. The local reaction has always been quite moderate even in the acute period. The pain is easily borne and often disappears at the end of an hour's time. There is but little tumefaction of the glans, no hæmorrhage, and the discharge is of a sero-purulent nature and relatively slight in amount. The nitrate of silver is equally held by Dr. Aubert (of Lyons) to be the anti-blennorrhagic *par excellence*. Thus, in his recent notes upon blennorrhagia in the female, he gives the following advice: When it is known that the mother has the disease, it is absolutely necessary that the eyes of the infant be washed immediately after its birth and a few drops of a one-to-fifty nitrate-of-silver solution instilled to prevent ophthalmia. Treatment of blennorrhagia in women should be limited to external means, as internal treatment exerts no influence. In urethral blennorrhagia of women no injection is to be compared in point of efficacy to that of nitrate of silver even in the strength of one to three hundred. In cases of rebellious urethral blennorrhagia the introduction of a stick of nitrate of silver into the canal gives good results; but this introduction should be made rapidly, so that the cauterization does not take place too deeply. Blennorrhagic vaginitis of young girls should be treated by frequent hot irrigations with a boric-acid solution of one to one hundred, and by insufflations of iodoform-powder within the vagina. In women, whether the vaginitis be acute or chronic, the best means to effect a cure consist in applying a stick of nitrate of silver lightly over the surface of the vagina every four or five days. The folds of the mucous membrane must be spread out for this purpose by means of the valves of a speculum. Each day the patient should take in addition an injection of a decoction of walnut-leaves, of poppy-heads, or of salt and water. To cure blennorrhagia of the neck of the womb, it is sufficient to introduce once or twice the nitrate-of-silver stick within the cervix. Anal blennorrhagia gives way equally to cauterization either with the solid stick or injections of a solution of nitrate of silver. Dr. Erand describes three forms of blennorrhagic metritis: 1. The *hyperæmic form*, with redness, congestion of the cervix, and a short duration of from two to three weeks. 2. The *ulcerating form*, characterized by erosions situated especially upon the posterior lip of the neck. 3. The *hypertrophic form*, which is long lasting, and which does not recognize the gonococcus as the only cause, but also various traumatismis, pregnancy, confinement, etc. According to the author, the cervix uteri is one of the locations of predilection of the gonococcus, and it must be sought for in the uterine secretions in order to make the diagnosis. He places little

or no confidence in internal treatment for this uterine metritis. Scraping out the uterus with a Volkmann's spoon is required, and injections or washings with anti-parasitic solutions or with solutions of nitrate of silver in strength of one to thirty, one to forty, or one to fifty.

PARIS.

DR. L. BROcq.

#### THE TREATMENT OF KELOID AND HYPERTROPHIED SCARS BY ELECTROLYSIS.

*To the Editors of the Journal of Cutaneous and Genito-urinary Diseases :*

DEAR SIRs: In a recent discussion on the treatment of keloid by electrolysis, at the meeting of the American Dermatological Association (*vide* "New York Medical Journal," Dec. 1, 1888), Dr. Heitzmann spoke of the favorable results reported by me, but stated that Dr. Althaus, of London, had given up the treatment, and that he (Dr. H.) also had failed of success in one case. Dr. Fox had tried the method in five cases of true keloid, and also in hypertrophied scars, but had obtained only temporary benefit. Dr. Morison, on the other hand, had secured good results in hypertrophied scars, and also in one case of keloid in a negro. Dr. Rohé had had no opportunity to test electrolysis in keloid, but he also had diminished the size of scars in this way. Dr. Rohé further referred to the paper of Brocq, of Paris, who claimed successful results from the electrolytic method. As I have published nothing on this subject since my short article in the "Philadelphia Medical Times," May 29, 1886, I trust you will allow me space for a few words of explanation. If any one will take the trouble to read that article he will discover that my claims for electrolysis in keloid were of the most modest sort. I called attention to the fact that in a paper written in 1883 ("St. Louis Courier of Medicine," June, 1883), on the general subject of electricity in dermatology, I mentioned the results that I had obtained in the betterment of hypertrophied scars by electrolysis, and that I further urged a trial of it in true keloid. A number of cases of hypertrophied scars thus successfully treated are then recorded. At the conclusion of my communication to the "Medical Times" I put on record the electrolytic treatment of a single case of a keloid which had followed the extirpation of a bean-sized mole. The growth was of the circumference of a silver half-dollar and was a quarter of an inch in height, and the patient complained of sensations of pain and burning in it. I operated on it by electrolysis, and I stated in the article mentioned that the tumor disappeared, and in its place was to be seen only a smooth white scar. Some two weeks ago, or about four years after the removal of this growth, I saw the patient again, and the keloid, if such it were, had not returned. I conclude my short note with the following paragraph :

"It is just possible that this keloid and the hypertrophied scars may have spontaneously disappeared; but I am so strongly inclined to the belief that the results obtained were the result of the treatment employed, that I have been encouraged to place these notes before the profession."

After reading this quotation, I think no one will charge me with bringing forward a specific treatment for keloid. I thought then, and I think now, that the facts that I had observed were worthy of record. Now, for the last four years, owing to various causes, I have had little chance of making fur-

ther trial of electrolysis in keloid. I have had only one case under my care that I was able to follow up thoroughly, and, as it represents a partial failure, I shall give a few of the details.

I first saw Miss N. in October, 1887. The growth, situated on the right side of the neck, had been in existence for about ten years. Two years before, it had been extirpated, but soon returned. When first seen it was about the size of a filbert, elevated about an eighth of an inch, pink in color, and the seat of some pain and pruritus. After the first few operations the growth materially diminished in size, and later on almost entirely disappeared. In some two months more, however, the growth had begun to enlarge again, but it never reached its original dimensions. I then operated once more, and about seven months elapsed before I had an opportunity to make an examination. This time I found that the reduction in size had been considerable and apparently permanent; indeed, the patient was gratified with the improvement, and wished a continuance of the treatment.

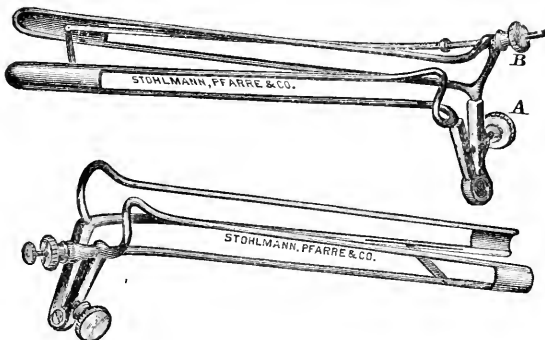
It would seem, therefore, established, from a consideration of the foregoing facts, that the testimony of a number of competent observers goes to prove that electrolysis is an agent of value in hypertrophied scars; and, secondly, that, notwithstanding the failures, a limited number of cases of keloid have either been materially improved or altogether cured by the electrolytic procedure. Consequently, I should advise that, before curtly dismissing this method of treatment as of no value, it would be wiser to delay judgment for a while longer. From certain observations that I have made, it occurs to me that the manner of electrolyzation has been faulty, which would explain the differences of result. I shall proceed immediately to look into this subject with the new light that I think I possess, and report at an early day.

Respectfully,

W. A. HARDAWAY.

St. Louis, *February 2, 1889.*

**New Urethral Speculum.**—In the May, 1888, issue of this Journal I described and showed an improved urethral speculum. It was novel in having independent expansion of its arms at both base and tip. Thus the arms can



be brought into a parallel position, or can converge at either extremity. These changes are constantly under the control of the operator by the two screws at A and B. I will here, however, not ask space to repeat a descrip-

tion of the original, but merely call attention to improvements which the skill of the makers has enabled me to effect in the present instrument, and which are readily seen by contrasting the two cuts.

1. Formerly the lever for spreading the tips came in the line of vision. This is now obviated by placing it between the two lower bars of the side-arms, one of which is hollow and carries within it the rod controlling the lever by the screw-nut B. This at the same time removes the rod from an awkward position. The free end of the lever can be removed for cleaning through a button opening at the end of its slot.

2. As the lever now has no direct bearing upon the plate-tips, they have been shortened, but enough retained to facilitate the introduction and give a comfortable base during urethral expansion. In thus shortening them, the concave tips have been omitted, and a slight increase in the visual field gained thereby.

In suitable cases this open wire bivalve, controllable at both ends, is vastly more serviceable than the endoscopic tube, which yields but a limited and changing field, and which does not afford the instantaneous localization of slight or marked contrast in the continuous expanse of mucous membrane examined. I find the ordinary reflecting head-mirror sufficient to give moderate illumination. The various forms of electric light serve, however, the purpose better and are easier to control. The adaptation of the Oberländer inserted light with this speculum would, I believe, be the most efficient means of ocular demonstration of the urethra yet presented.

40 EAST THIRTY-FIRST STREET.

F. TILDEN BROWN.

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## Selections.

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### Raynaud's Disease.

MANY points still remain unsettled in the question of symmetrical gangrene, and the report of two cases of this remarkable condition by Dr. Affleck, in the "British Medical Journal" of December 8, 1888, accompanied by a chromolithograph, adds to our knowledge of the subject. Sensory disturbances are first noted, followed by sudden and marked ischæmia, affecting more particularly the points of the fingers and toes, but at times as well the lobes of the ears or tip of the nose. At first the parts are pallid and corpse-like, pain is often intense, and numbness may be present, with hardness of the tissues. This local syncope is supposed to be due to arrest of blood-supply from spasm of the arteries. This stage may continue or pass off, and the parts regain their normal appearance. Extreme lividity and swelling, with painful burning feelings, may ensue, due to engorgement with venous blood. This stage may also pass off or increase and advance to gangrene of the parts. This is usually the dry form of gangrene, and superficial, involving the upper layers of the skin. An ulcerated surface results and cicatrization takes place, with loss of tissue, extending at times to one or more phalanges, and in rare

instances (as in one of the cases reported) to half of one foot, necessitating amputation, and nearly all the toes of the other.

In the second case there was a remarkable abnormality of blood-supply to the affected hand and arm. From the first, and during the whole course of the disease, no pulse could be made out anywhere in the hand or arm below the axilla. It was considered that there was probably a high division and unusual distribution of the brachial artery as a congenital condition, giving an inadequate or inefficient blood-supply to the parts concerned. The patient had been for six months subject to attacks of pain in the hands and feet. It had passed away from the feet, but persisted in the right hand, being worse at night, and the tips of the fingers had become blanched.

The question is asked whether the vascular changes are sufficient in themselves to bring about such serious results as instanced in these cases? It is not certain that the arrest of arterial flow is absolute, and is not of long continuance at any one time, but often alternates with a state of engorgement. It does not appear to be always present, and may appear and pass off so quickly that it can not be held to be the direct cause of the death of the part. The further stage of cyanosis is never absent in a well-marked case, and always precedes the death of the part. A pre-existence of trophic defect is assumed with a lowered tissue vitality. This seemed to have been the case in the author's first observation. Extreme chilling of the feet by exposure for two days to wet and snow was doubtless the exciting cause, bringing about in already ill-nourished tissues such vascular disturbances as usher in Raynaud's disease. In the second case, arterial defect maintained a chronic lowered vitality of the hand and arm. The frequent pre-existing neuralgias and paræsthesia also point to trophic disturbance. Sections of the internal plantar nerve from the amputated foot showed that extensive neuritis had existed and degenerative changes were going on, many of the bundles being entirely destroyed and replaced by fatty matter.

#### Capillary Aspiration of the Bladder.

ROSENBERGER claims that aspiration of the bladder is easily carried out, is less painful than catheterization, is always successful, and absolutely harmless if the ordinary rules of antiseptis are observed. It is indicated in any case of retention of the urine in which the cause is removable and where catheterization has failed. A cannula of the size of an ordinary knitting-needle is pushed into the bladder through the linea alba immediately at the symphysis pubis. When the bladder has been emptied, the cannula is withdrawn and the opening compressed until it has become sealed. When retention recurs, the aspirator is to be used again and repeated until the catheter can be passed or the patient is able to urinate. No reaction follows if strict antiseptis of the parts operated upon and of the tube be carried out.—*Pittsburgh Medical Review*, December, 1888.

#### Unusual Errors in Diagnosis of Chancre.

IN a lecture upon *Des erreurs de surprise dans le diagnostique du chancre syphilitique* ("Gaz. des hôpitaux," Nov. 20, 1888) Fournier speaks of the factitious indurations due to circumscribed infiltrations of tissue from vari-

ous causes, which have a hardness at their base closely simulating the characteristic induration of chancre. They may be produced by the application of caustics, by medicinal dressings, and by topics which the patient has used on his own account before presenting himself to the physician. The principal caustics capable of producing this effect are sulphuric and nitric acids, the acid nitrate of mercury, acetic, chromic, and phenic acids. He cites a case of a woman who, to cure an obstinate fissure of the lip, applied nitric acids, and came to the St. Louis Hospital with a lesion absolutely similar to a chancre. Sulphate of copper and alum are often applied by the patients themselves, and in the army the ashes from the pipe, and urine, are highly prized curative agents. The questions should always be asked when a new patient presents himself for treatment : 1. Has the sore been cauterized ? 2. Has any topical application been used ?

### Drug Eruptions.

LESSER reported in "Deutsche med. Wochenschrift," 1888, No. 14, two cases of drug eruptions which had lately come under his observation.

The first case occurred in a student whom he began to treat, by calomel injections, for a recent sclerosis. On the following day, eleven hours after the injection, the skin over the entire body was of a scarlet color. In the course of two or three days the redness began to fade, while on the fifth day desquamation began, which later involved the entire epidermis. The treatment was changed to the internal use of the tannate of mercury, after which no eruption occurred.

The second, a case of erythema nodosum, came on two days after the internal use of iodide of potassium ; the use of the sodium salt was followed by the eruption in a less severe form. The treatment, after being changed to the subcutaneous use of the potassium salt, was followed by no eruption.

Dr. Max Engelmann reports in the "Münch. med. Wochenschrift," 42-88, the case of a patient suffering with chronic metritis and insomnia at the menstrual periods, to whom two grammes of sulphonal were given ; it failed to produce sleep, but on the following morning a diffuse scarlet rash was seen on the outer side of both mammæ. The borders of the rash, at first sharply defined from the adjacent skin, gradually spread over both breasts and arms, finally changing to a darker hue, and then disappearing.

Dr. Johann Bokai, Jr., reported in the "Orvasi Hetilap" three cases of herpes zoster following the internal use of Fowler's solution for chorea minor. In the first case, a girl nine years of age, the eruption appeared after 157 drops had been taken in thirty days. A second patient, a girl aged ten years, developed the eruption after forty-eight days' treatment with 250 drops of the drug. In the third case, a girl aged ten, 320 drops were taken in fifty-four days before the eruption appeared. Bokai confirms the observations of Hutchinson, Duckworth, Finlayson, and Rebouls, that arsenic can produce herpes zoster.—*Monatshefte für praktische Dermatologie*, Band viii, No. 1.

In the "Münchener med. Wochenschrift," No. 38, 1888, Dr. Rudolph von Haesslin gives the following history of a case of picric-acid dermatitis : Early in August a patient with an unusual skin affection was brought into the

hospital; he had two weeks before bought a pair of low shoes which were lined with orange-colored leather; six or eight days later he noticed a violent itching of both feet, which increased from day to day. The itching became so intense that sleep was impossible. He noticed now that both feet were colored yellow as far as they were covered by the shoes. Thinking that the skin affection might be caused by the shoes, he discarded them for others. The coloring matter having already penetrated the epidermis, the itching and burning increased. On the external and internal borders of both feet, as well as on the soles, a number of vesicles filled with yellow-colored serum made their appearance. Both feet at this time were reddened, painful, and œdematous. As the patient was no longer able to walk about, and as his general health began to suffer, anorexia, headache, sleeplessness, etc., being present, he entered the hospital. The leather of the shoes was subjected to a chemical examination, and was found to be saturated with picric acid, so that by merely rubbing it with the moist finger it came off. The small vesicles which first appeared became larger, until finally the whole epidermis of both feet, as far as they had been covered by the shoes, was elevated by a purulent serum. After rest in bed, elevation of the feet, and the application of borie-acid dressings, the patient soon recovered.

#### **Diphtheria of the Bladder.**

ORLOWSKI ("Gaz. Lekarska," No. 14, 1888) reports a case of diphtheria in a three-year-old girl which was improved after eight days of treatment. Suddenly profuse bleeding occurred from the vulva, the urine became thick, turbid, and very foul-smelling. These symptoms passed away rapidly, but returned in a more severe form after some days, followed by retention of urine. The catheter brought away very foul-smelling urine: there then appeared at the urethral orifice a gray-colored slough, attended by cramp of the bladder, which, after removal by the pincette, was followed by the flow of more stinking urine. The slough was composed of a twenty-five centimetre piece of bladder mucous membrane. After washing out the bladder daily with a four-per-cent. borie-acid solution, the child was cured within a few days.

#### **Treatment of Leukoplakia Buccalis by the Balsam of Peru.**

THE article by Dr. Rosenberg from Lassar's clinic in Berlin is based upon the observation of thirteen cases, one of which is that of the author himself.

The treatment consists in painting the affected parts with the pure balsam of Peru. The painful and fissured spots are painted by means of a soft brush, while on the insensible spots it is well to make frictions by means of a hard pencil. These paintings and frictions should be made from one to three times a day by the patient himself.

After each application the balsam should be retained in the mouth at least from three to five minutes. The applications always provoke a slight burning sensation and a profuse salivation. It is necessary, however, that the patient resist the desire during several minutes to eject the saliva. Two other indispensable conditions to success are the employment of a medication of good quality (the balsam of Peru being often adulterated), and a

treatment sufficiently prolonged to suit the exigencies of each case. The pains often disappear within a few days, and a cure is sometimes effected within a few weeks. In other cases the treatment must be much more prolonged. The author was obliged to make use of the applications during fifteen months (once a day) in order to definitely cure two spots of leukoplakia, one of which was situated upon the tongue, the other on the mucous membrane of the buccal cavity inside the cheek. From nine cases so treated, Dr. Rosenberg obtained a cure in eight, and until the present time without a return. The eighth case was only ameliorated. This relative success does not invalidate the value of the medicament, for, in the first place, the case was one of twenty-five years' standing; and, furthermore, what treatment is there, however efficacious, that does not sometimes fail?—*Bulletin Médical*, Nov. 4, 1888.

### **International Congress of Dermatology and Syphilography.**

As announced in the September, 1888, number of the JOURNAL, an International Congress of Dermatology and Syphilography will be opened in Paris on Monday, the 5th of August, in the grand hall of the Museum of the Hôpital St. Louis.

We make the following extracts from the announcement which has been sent to each member of the American Association of Dermatologists and the American Society of Genito-urinary Surgeons :

Any physician who desires to join the congress may do so by sending his name to M. le Dr. H. Feulard, Hôpital St. Louis, Paris, Secretary of the Committee of Organization, or to one of the foreign secretaries (for America, Dr. P. A. Morrow, 65 West Fortieth Street, New York).

The fee required for membership, twenty-five francs, may be paid at the opening of the congress, and will entitle the member to the published proceedings of the congress.

Any member who desires to contribute a paper to the congress is requested to forward its title, together with a brief *résumé* of its contents, to the Secretary of the Committee of Organization, or to the writer's home secretary, before the 15th of May, 1889.

This *résumé* will be printed in whole or in part in the general programme which will be distributed before the opening of the congress.

A programme will be issued about the first of July containing the names of those members which were received before the 15th of May, the titles of the communications received, together with the names of the members who will take part in the discussion of the announced subjects (*questions mises à l'ordre du jour*).

### **German Dermatological Association.**

IN June of the present year the first annual meeting of an association composed of dermatologists from Germany, Austria, as well as from other countries, will be held in Prague. Any physician especially interested in dermatology or syphilography is eligible for membership, in regard to which application can be made to Prof. F. J. Pick, President, 41 Jungmann Strasse, Prague.



## Book Review.

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*The Operative Treatment of the Hypertrophied Prostate.* By FRANCIS SEDGWICK WATSON, M. D., Boston. In one volume of 167 pages, illustrated. Boston : Cupples and Hurd.

THE author has presented in this volume, which has rather the appearance of an attractive atlas, the substance of a paper which he read at the last meeting of the American Association of Genito-urinary Surgeons.

The obstruction which hypertrophy of the prostate offers to the flow of urine from the bladder has at different times led surgeons to attempt a cure by means of sounds, caustics, ligature, enucleation, removal of the median enlargement by means of lithotomy forceps or instruments passed by the meatus, division of the bar at the neck of the bladder, etc. Suprapubic cystotomy has recently been revived and made use of by some for prostatic operations, according to the method of Petersen, while perineal or urethral prostatotomy and prostatectomy have been the operations chosen by others, while nowhere has there been a well-defined policy, and some even condemn radical operations altogether.

It has been the author's endeavor, in this excellent work, to formulate, out of these various proposed means of treatment and diversity of views, a rational groundwork upon which operation can be based, so that, in a given case of prostatic enlargement, the surgeon can choose the procedure indicated by the conditions present. In accomplishing this, he has succeeded in making a valuable addition to a rather obscure chapter in genito-urinary surgery. The various operations are discussed in the light of prevalent surgical opinions, and it is demonstrated not only that in appropriate cases surgical treatment is demanded, but also that the choice of radical operation must lie between the perineal and suprapubic methods.

Thirty-four beautifully executed full-page photogravures, from specimens illustrating the pathological conditions treated of, occupy the body of the work. Each plate is accompanied by a page of explanatory text, giving anatomical data, and pointing out the operation which would be appropriate in each case. These illustrations add materially to the interest of a most interesting subject, and, together with the general neat appearance of the printer's work, reflect much credit upon the publishers.

C. W. ALLEN.

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## Books and Journals Received.

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Lichen Ruber as observed in America and its Distinction from Lichen Planus. By R. W. Taylor, M. D. [Reprinted from the "New York Medical Journal," January 5, 1889.]

Some Dermatological Don'ts. By George Thomas Jackson, M. D. [Reprinted from "The Medical Record," December 29, 1888.]

Dermatitis Tuberosa als Folge von Iodkaliumintoxication; die sogenannte anthracoïde iodopotassique. By R. W. Taylor, M. D. [Sonder-Abdruck aus "Monatshefte für praktische Dermatologie," vii. Band, 1888, No. 24.]

Erythematous Lupus of the Hand. By A. H. Ohmann-Dumesnil. [Reprinted from the "American Journal of the Medical Sciences," December, 1888.]

Urinary Examination in Localizing Gonorrhœa. By H. Goldenberg, M. D. [Reprinted from "The Medical Record," December 15, 1888.]

Success and Failure of Electrolysis in Urethral Strictures, especially Dr. Keyes's Method reviewed. By Robert Newman, M. D. [Reprinted from the Philadelphia "Medical Times," December 15, 1888.]

The Electrolytic Decomposition of Organic Tissues. By George H. Rohé, M. D. [Reprinted from the "New York Medical Journal," Dec. 1, 1888.]

Multiple Chances of the Hard Palate. By A. H. Ohmann-Dumesnil, M. D. [Reprinted from "Progress," October, 1888.]

Note sur deux cas d'urticaire pigmenté, forme maculeuse à caractères frustes. Par Louis Wickham et A. Thiboult, internes des hôpitaux, Paris. [Extrait des "Annales de dermatologie et de syphiligraphie."]

Wood's Medical and Surgical Monographs. Vol. I, containing The Pedigree of Disease. By Jonathan Hutchinson, F. R. S. Common Diseases of the Skin. By Robert M. Simon, M. D. Varieties and Treatment of Bronchitis. By Dr. Ferrand. Vol. II, Gonorrhœal Infection in Women. By William Japp Sinclair, M. D. On Giddiness. By Thomas Grainger Stewart, M. D. Albuminuria in Bright's Disease. By Dr. Pierre Jaenton.

The Waters of Plombières (Vosges). By Dr. Bottentuit. London: J. & A. Churchill.

A Clinical Study of the so-called Prairie Itch, Lumberman's Itch, etc. By William T. Corlett, M. D., L. R. C. P. Lond. [Reprint.]

Zur Casuistik des Bromexanths. Von Dr. Carl Szadek. [Reprint.]

Treatment of Strictures of the Male Urethra by Electrolysis. By J. D. Thomas, M. D. [Reprint.]

Ueber das Exanthem des Flecktyphus. By Prof. Dr. Victor Janovsky. [Reprint.]

The Curability of Urethral Stricture by Electricity: an Investigation. By E. L. Keyes, M. D. [Reprint.]

The Failure of J. B. Thomas's Treatment of Urethral Stricture by Electrolysis. By Robert Newman, M. D. [Reprint.]

Zur Desinfection der menschlichen Haut mit besonderer Berücksichtigung der Hände. By Dr. Paul Landsberg. [Reprint.]

Index Bibliographicus Syphilidologie. By Dr. Karl Izadek. Erster Jahrgang. 1886.

Des gales anormales. Par Arthur Heem, Docteur en médecine.

On Preventive Treatment in Primary Syphilis. By Edward Bennet Bronson, M. D. [Reprint.]

Dermatitis Tuberosa due to Ingestion of the Iodine Compounds. By James Nevins Hyde, M. D. [Reprint.]

Zur Pathologie der männlichen Harnröhre. By Dr. H. Goldenberg. [Reprint.]





# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### THE SYPHILOMA OF THE VULVA.

By JAMES NEVINS HYDE, M. D.,

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THE term "syphiloma" was first employed by Wagner in 1864 in designating the neoplasm of syphilis, including both the initial sclerosis and later lesions of the disease. Without definitely determining the pathological identity of these two, the term has been more recently limited to the description of certain of the later manifestations of syphilis, whether exhibited as diffuse or circumscribed infiltrations, tumors, or the secondary changes to which these morbid growths are subject. Briefly, it is, for any viscus or region of the body, the deeper gummatous changes occurring in the later, so-called tertiary periods of syphilis, as distinguished from the earlier, more superficially situated symptoms of the disease, which the word syphiloma usually describes. In the pages which follow it is purposed, under the title syphiloma of the vulva, to portray the symptoms of gummatous involvement of that organ, whether partial or complete, occurring in women who have been for a variable period of time infected with syphilis.

This description is based not merely upon a group of interesting cases observed by the author, but also upon those recorded under various other titles in medical literature and unmistakably belonging to the same category. It was originally the intention to make a mere contribution to the general subject by reporting these personal cases in the usual form. A general survey of the field, however, encouraged the belief that the time had come for taking a more venturesome step. Out of the midst of the confusion which has undeniably prevailed respecting the nature, symptoms, course, and connections of a large number of vulvar lesions differing in type, it is right and proper that syphilis at last should claim her own.

*Symptoms.*—The syphiloma of the vulva is rarely subjected to study in its earliest manifestations, partly because its painless and often insignificant beginnings are readily overlooked for long periods of time ; partly because of the instinctive unwillingness of women to expose for examination lesions of the genital region whose presence can be tolerated without marked discomfort. The syphiloma, when first recognized, is usually a deep-set, well or ill defined, firm, bean- to nut-sized infiltration of the submucous or subcutaneous tissue of one labium majus. There is commonly a history of insidious development after the date of its first observation, rarely of pain or tenderness. Occasionally there has been moderate or severe genital pruritus. Next in order of site of first development, after the labia majora, may be named the labia minora, the vestibule, the urinary meatus, the clitoris, the fourchette, the perinæum, and the skin covering the mons Veneris. It is particularly necessary to note that in the majority of cases the inguinal glands are quite unaffected ; that physiological or morbid discharges from bladder or uterus, though occasionally aggravating the lesions observed upon and about the vulva, have no essential connection with the latter ; that in every accurate history or exact observation of the case ulceration has always been preceded by some such change as that briefly described above ; and, lastly, that time is of the essence of the diagnosis, no such brief intervals as those, for example, sufficient for the evolution of the chancre, spanning the period between the dates set as those of first recognition and later observation of the lesion.

We note also at this point that the neoplasm is commonly first developed at a given point in the external organ of generation, and does not reach this point after extension from the internal generative tract. Next, that its first beginnings are not observed in the groin, the inner face of the thigh, or the lower belly, whence it has spread to the invasion of the vulva. Lastly, that if a line be drawn at right angles to and bisecting the axis of the vulvar cleft, the initial gumma will usually be discovered above rather than below this imaginary line ; and its extension later will be generally downward toward the perinæum rather than upward over the pubes. It may be conjectured that the selection of this site of earliest development may be due to the irritating effects of the urine in its passage over a tissue predisposed to mischief.

In order to understand clearly the several possible phases of evolution and involution which the gummatous nodule, after a first development in one of the parts named, may subsequently traverse, it will be useful to examine the picture presented when the typical syphiloma of the vulva has reached its fullest development. It is scarcely necessary to add that this extreme picture has been very rarely observed, though its outlines are projected in almost every clinical portrait of the disease.

In such rare and complete evolution, then, the syphiloma of the vulva

is distinguished as a more or less symmetrical enlargement of the labia majora of both sides, constituting thus a tumor whose shape may be coarsely compared to that of a horse-collar, its bulkier masses above terminating gradually below in an infiltrated perineal ridge. The skin covering these parts is either unaltered or is infiltrated, and reddish, pinkish, purplish, or of a deep violaceous hue. The clitoris above is enlarged, and may be represented by one, two, (rarely) three or more smooth or irregularly knobbed, softish, or firm projections, varying in size from a small bean to the distal phalanx of the thumb. The vestibule is thickened, mammillated, and superficially or deeply ulcerated, this ulceration often eroding the lips of the urethra, more rarely boring to the extent of several millimetres into the outer third of that channel. In these cases the ulcer, reaming into the urethral orifice with its outlying cylinder of infiltration, strongly suggests certain phagedenic chancres working similar mischief far more rapidly at the orifice of the male urethra. Again, examination of this part with the finger may reveal only a diffuse infiltration of the mucous membrane or a group of circumscribed nodules, varying in size from a large millet-seed to a split pea, seated chiefly in the region of the vestibule. The same is practically true of the dense masses constituting the voluminous labia majora, where at times distinct marble-sized tumors may be defined in the mass, seemingly of a stony hardness. At other times the homogeneous, smooth thickening produces the impression upon the finger of fibrous tissue. The labia minora, representing the lateral parts of this hollow cylinder of gummatous infiltration, are either similarly altered, distorted, and projecting, or at their free borders and internal faces the seat of ulceration. This ulcer, unilateral or symmetrical, more commonly the former, may, especially where the nymphæ and labia majora of one side unite, penetrate in a crateriform funnel, pointing toward the ramus of one ischium. It resembles the ulcer noted above, having very irregular edges—rarely, if ever, the clear-cut outlines of the ulcer following the degenerating gumma of the subcutaneous tissue of the leg, for example—and furnishes a scanty, at times distinctly purulent, secretion. In extreme cases it unites by a serpiginous tract with the ulcer of the vestibule lying above. Centrally, it may fuse with an eroded ring of tissue composed of mucous membrane infiltrated with gummatous material, encircling the introitus vaginæ and extending upward for a centimetre or more into the vagina itself. In such cases there is often a noticeable contracture of the vaginal orifice, which will scarcely admit more than the point of one finger, and the vagina itself is retracted toward the deeper pelvis. Its color is reddish, or more often violaceous and impurpled. In women advanced in years the color may be livid, leaden, or ashen gray.

Reference has been made to the perineal infiltration seen in some cases. It is to be noted that in these a somewhat singular appendix to the vulvar

syphiloma may be often recognized in the shape of certain firm, fleshy, flattened, broadly attached masses, bean-sized to small egg-sized, one or several of which may surround the anus. These tags resemble the slices of a somewhat firm tumor, and may be covered with a delicate pellicle, or be granulating, hæmorrhagic, or pus-covered; rarely ulcerated. They are termed "*languettes*" by French authors, in consequence of their occasional tongue-shaped outlines. They may concur with a gummatous infiltration of the anus, extending for a short distance above its upper verge. It is noteworthy, however, that a typical case of what is now well recognized as the syphiloma of the rectum has not yet been reported as complicated by the lesions here described. The tongues, tags, or warty tumors described above have been often termed condylomata, and certainly do at times suggest these lesions in size, situation, and superficial appearance. But they occur at epochs widely separated in time from those when condylomata most often form, and are recognized only in patients having gummatous infiltrations of either the vulva or the anus. They are not themselves the seat of such gummatous deposit; at least none such has been recognized in sections removed and examined by myself. They seem to be purely hyperplastic growths, incited to development by interference with the nutrition and functions of the neighboring parts. The anus about which they form may be ulcerated, infiltrated, or retracted within the vagina. Here, as in the first development of the syphiloma of the labium or vestibule, the inguinal glands commonly exhibit no trace of the disease.

When viewed as a whole, this group of remarkable lesions may be regarded as tending to form a short, hollow, truncated cone, its blunt cylindrical apex occupying a point a short distance within the vaginal orifice, one angle of its base fixed in the dense and voluminous labia majora, the other in the infiltrated junction of the fourchette and perinæum. At its periphery, this cone is represented by a dense and unyielding mass; centrally, by a softer and equally infiltrated tissue, liable to degenerate by ulceration. In a series of cases, however, variation in all features may be noted. Sometimes the organs attaining the greater dimensions are the seat of a distinct œdema. Again, the labia majora may be furrowed, ridged, or the seat of fungosities. At times the altered tissues are softish, doughy, or elastic, rather than dense; and the skin, when not of the more common violet tint, is smooth, white, and polished, or distinctly vascularized. At times the whole is bathed in an abundant pus, furnished, not by the altered tissues, but by organs more deeply situated, whose discharge is conveyed downward by the channel of the vagina or urethra.

Gigantic ulceration and portentous destruction of parts may complicate all these conditions after occurrence of phagedæna or gangrene. The urethra may be cleanly dissected from its supports, and fall down as a free flap over the vaginal orifice; or the vagina and rectum may be converted,



as in one of the cases under the author's observation, into a wide chasm, traversed by one or more bridges, relics of vulvar or vaginal connective tissue. These serious conditions are very rarely, however, the direct results of the syphilitic process. They most often follow the accidents of childbirth, in either natural or artificial delivery, where lacerations have occurred in a tissue rendered inapt by its gummatous changes for the requisite distention.

From its simplest first lesion to its widest multiform complications every grade of evolution of the vulvar syphiloma may be distinguished in a period covering from one to three or more years. In one case a marble-sized gumma may be found in the substance of one labium majus, covered by an unaltered integument, which may never increase in size or undergo complete absorption; again, a labium majus of one side may be transformed in a year into a dense, smooth, or rigid tumor, covered with purplish or vascularized skin, projecting boldly from the vulvar plane, suggesting in appearance the impurpled half scrotum of the male sheathing an intractable syphilitic testis of one side. Still again, the vestibule alone, or the vestibule and adjacent parts, are dull-reddish in color, mammillated, thickened, and unyielding, gouged here and there with dentated ulcers, secreting a sanious matter, and interspersed with millet-seed sized and larger nodules, representing points of gummatous deposit. When the vestibule is involved, the ulcerating line will at times observe the contour of a horse-shoe, its open ends pointing downward, the resemblance being more striking when, in favorably progressing cases, the whole is defined at the periphery by a whitish line of advancing cicatrization.

Rather more rarely the ostium vaginae is affected, when the labia, nymphæ, and clitoris are intact. In these cases, if the labia are well separated, one or several fleshy and pendulous fungosities, tags, or vegetations may be found attached to one side of the vaginal wall, which alone is infiltrated and dense; or an exceedingly irregular and indurated ring of infiltrated mucous tissue, eroded or ulcerated on its inner face, is found occluding the vaginal orifice.

The subjects of the disease whose symptoms are described above are, almost without exception, women between the second and fifth decades of life, by far the larger number suffering between the twentieth and thirtieth years—periods of most frequent occurrence of acquired syphilis in the two sexes. They may be pallid, cachectic, and emaciated, or exhibit, as is frequently seen in cases on record, all the evidences of general health. Many are well-nourished, wholesome-looking women, giving no clew whatever in external appearance to the degree of deformity actually present in the vulva. They are also, as a rule, entirely free from any other evidences of syphilitic infection. This fact, which has been viewed by some writers as a singular and exceptional feature of the disease, is the actual rule for

the majority of cases. At times one gets a history of chancre, specific exanthemata, or other unmistakable signs of infection. Occasionally also a tell-tale cicatrix on one leg, or a group of pigmented tubercles about the brow, or a circle of partly ulcerated nodules on the buttock, confirms the story told by the genital lesions. Most such cases, however, are those of public women treated in the hospitals of France. In the average American patient such history and such concomitant symptoms need not be expected.

With regard to the functions of the body, micturition is in the highest degree painful when a vestibular ulceration does or does not invade the urethral lips or channel; and defecation is not only exquisitely painful, but accompanied by the emission of blood when the anus is beset by the fleshy tags described above. In the absence, however, of both vestibular ulceration and ano-rectal involvement, the subjects of the disease, even when displaying well-developed lesions of the vulva, are singularly free from subjective symptoms. Coitus is practiced repeatedly when the vulvar lesions are not grave in character. No careful observer indeed can for any length of time carefully follow the career of one of these patients in private life without becoming convinced that the abuse of these organs, in attempts to gratify the sexual instinct, is the fruitful cause which aggravates and perpetuates the morbid condition. It follows, almost as a corollary from the above, that the cases reported as occurring in virgins are either misinterpreted or are instances of inherited disease. I have been unable to discover the record of a well-marked case of vulvar syphiloma in a virgin infected with non-venereal syphilis.

Further, the instances are few where the syphiloma of the vulva has been recognized as a late manifestation of inherited disease; but in these it has exhibited nearly the same features as those detailed above. Fournier reports one such in the case of a virgin, eighteen years old, who had never menstruated, whose family history betrayed the usual mortality record among the children, and who exhibited characteristic dental and corneal changes. There were multiple circumscribed ulcerations of the labia having clean-cut edges and violaceous borders. In another case there was the characteristic sclerous, elephantiasic enlargement of one labium, which had not failed to be described by another French physician as "esthiomenus of the vulva," the common lot of so many of these syphilomata.

*Ætiology and Diagnosis.*—In the preceding paragraphs an attempt has been made to describe symptoms occurring only in the subjects of syphilis, that disease being in any case of prime ætiological importance. It is clear, however, that, waiving for the moment a consideration of the exact causes of syphilis, even in the infected the physiognomy of the vulvar syphiloma is greatly modified by the anatomical peculiarities,

physiological functions, and abuses of not only the chief organ involved, but of those in connection with it.

Respecting the important question of diagnosis, it is scarcely necessary to refer to the wild confusion with which it has been overspread. Why, let us ask, have so many competent and conscientious observers, who were able not only to describe but also to faithfully illustrate in colors the clinical pictures presented, been unwilling to believe that they were actually confronted with syphilis in one of its manifold manifestations?

First, we may answer, the literature of this theme has been largely contributed by those specially devoted to the study of diseases of women; and they have so ably and persistently held the ground that, by almost common consent, the field has been abandoned to them. The ground, in fact, has scarcely been deemed worthy of contest. It is true that such distinguished authors as Barnes, Thomas, and Emmet scarcely refer to the subject in their treatises; but since the year 1848, when Huguier first attracted attention to lesions of this sort in his well-known essay on "Esthiomenus of the Vulva and Anal Region," reporting nine cases, careful writers have made further clinical contributions, and even critical discussions, of the theme. Among these may be named Fiquet, Guibont, Martineau, Matthews Duncan, F. Block, Spillmann, Rémy, and Boyd, abroad; and in our own country, Isaac E. Taylor, of New York; Grace Peckham, and M. D. Dunn. Distinguished as these authors unquestionably are in their relation to the literature of diseases of women, it is yet true that few physicians without a special training for the work are competent to distinguish syphilis in a single symptom or to identify its operations in an isolated scar.

This hesitation to accept the diagnosis of syphilis for the lesions in question is doubtless due in part to the failure of the gumma to conform to the common preconceptions relative to other genital manifestations of the same disease. Not only is the syphiloma of far rarer occurrence, it also does not in external features and career resemble chancres and so-called secondary lesions of syphilis having a vulvar site. Neither does it, as do these, yield speedily to the treatment effective in so many syphilitic phenomena. One of the writers above named, for example, looks to find something suggestive in the edges of the ulceration displayed in a certain case, and, failing in this, is in doubt respecting the nature of the malady because there is not conformity to the type of syphilitic ulceration in general. It would be difficult to name a single gynæcological author who has seriously discussed the diagnostic question from the point of view of the classical distinction between so-called secondary and tertiary (gummatous) phases of this multiform disease.

Again, the observers and writers identified with this subject seem to

be for the most part quite unconscious of the clinical fact that a woman with a gummatus lesion of the vulva may not only betray no other symptom of syphilis, but may exhibit all the other evidences of sound health. Axiomatic as this statement may be to the expert, it is one received with incredulity by the mass of practitioners. It rests, however, upon precisely the same clinical basis as its fellow—viz., that there are women and men in the world to-day who, by the most rigid scrutiny, can not be found to display the slightest evidence of a past or present syphilis, and yet who were unmistakably infected with that disease last year, and who next year may suffer from an amblyopia or a hemiplegia due to no other cause. Is it not safe to assert, for the mass of cases, that the man or woman with a single syphilis symptom has either a chancre or a gumma? How often does a muscular, red-cheeked, and well-nourished man without other traces of disease in his person seek relief for a gummatus orchitis! In truth, the more distinct the gumma, the fewer the chances of coexisting syphiloderma, mucous patches, and pilary loss. It seems almost idle to repeat these axioms, yet it is needful to recall them when we find a writer of the school described above claiming that syphilis was excluded from one case reported because there were "no nocturnal pains in the head or limbs, no cutaneous disease, and no affection of the mouth or throat."

Indeed, though such a statement can not yet be demonstrated as true for all cases, we are almost in position to assert, further, that women far more frequently than men exhibit single syphilitic symptoms. Many women during the active stages of syphilis seem to traverse periods when menstruation and child-bearing serve as depurating or symptom-carrying functions. A pallid wife, with only a hollow cheek and a persistent back-ache of which to complain, will perhaps exhibit a few scaling papules in the palm or a single mucous patch in the mouth. Another ruddy-faced, brawny, big-limbed woman, without another perceptible sign of ill-health, will bring into the world successively two or three puny, yellow-skinned, snuffling infants literally covered with syphilitic lesions. These women are not the exceptions to the rule. They supply the material for every public clinic. They furnish a body of evidence which, when judicially examined, disposes at once of the hesitations on this score of the school of the gynaecologists. They justify the positive assertion, if positive assertions are ever justified, that a woman with a vulvar syphiloma may exhibit no other evidences of infection, and that in the majority of these rare cases one may look for just this immunity. Touching the doubt thrown upon the diagnostic question by the failure of some of these patients to improve under syphilitic treatment, it can be readily seen, in careful examination of a series of recorded cases, that the gummata of the vulva are fully as amenable to a specific therapy as are the gummata of liver, testis, or brain.

But a yet more important inquiry, upon whose answer depends in part the diagnostic issue, is this: What, if any, erroneous titles, framed under the influence of the convictions described above, have the gynæcological school of authors, and those accepting their conclusions, chosen for the purpose of designating these vulvar lesions of syphilis?

First and most conspicuous among these may be named *lupus vulgaris*. Since the date of Huguier's early contribution to this theme, already cited, it is probable that more cases of syphilis have been recorded under the several names descriptive of lupus than under all others together. These names are *esthioménus of the vulvo-anal region*, *herpes esthioménus*, *esthiomène serpiginéux*, *dartre rongéante*, *lupus exedens*, *fressende Flechte*, *noli me tangere*, and various combinations of these words. But when the clinical statistics of lupus are consulted, the antecedent improbability of its invasion of the genital region is apparent at a glance. There is not a dermatological treatise in any language devoting even a page to lupus of the genital region. Hebra distinctly asserted that lupus is never of primary occurrence in this region of the body, its lesions, when here present, having invariably invaded the genital organs by extension from the thigh; yet in forty-eight cases of so-called *esthioménus of the vulva*, collated with admirable intent and great painstaking by Peckham, a crural origin and subsequent extension to the vulva is not once recorded. In one there is a record of simultaneous disease of the left thigh and right labium; in two others there was ulceration of the groins resulting from the bursting of abscesses in the inguinal glands. In as many more there were, as might be anticipated from what has preceded, isolated groups of pustules or nodules over the buttocks—the rare concurrent symptoms, in fact, of tertiary syphilis. In not a single one of all these reported cases does an author describe facial lesions of *lupus vulgaris*. These statistics will be further sought in vain for the discovery of any author who has taken the trouble to even record the fact that, though describing lupus of the genital region, a singular exception to the rule was seen in this, that no facial lesions of that disease were present. In a few instances, as might be anticipated *a priori*, a facial acne or acne rosacea—often probably a medicamentous acne—was noticed as coexisting with the vulvar symptoms.

*(To be concluded in May number.)*

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## CLINICAL OBSERVATIONS ON GONORRHOEA, WITH SPECIAL REFERENCE TO ÆTIOLOGY, DURATION, AND TREATMENT.\*

BY JOHN P. BRYSON, M. D., AND EDWIN C. BURNETT, M. D.  
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THE more widely our observations extend and the more accurate they become, the more thoroughly they seem to accord with the doctrine of the specificity of gonorrhœa. Every one seeing much of urethral inflammations recognized long ago a difference in the course and severity of symptoms in different cases, though there was no apparent difference in conditions under which they existed, so far as could be ascertained by a scrutiny of the affected individual. These differences in severity were ascribed by some either to "idiosyncrasy" or to a difference in the power of the "original irritant," while a few only claimed that the cases manifesting the severer symptoms depended upon an entirely distinct cause which they held to be a specific poison. The discovery by Neisser of the gonococcus, and the experiments of Bumm with cultures of this germ, with which he inoculated the hitherto healthy urethra, producing a gonorrhœa, establish this claim of specificity upon a reasonably fair basis. This is not, however, equal to the severe requirements of modern methods, and, when we attempt to approach this exact standard, we find that in the case of gonorrhœa three obstacles are encountered :

1. The difficulty in making cultures of the gonococcus.
2. The fact that the lower animals are not inoculable with the disease.
3. The difficulty, amounting almost to an impossibility, of getting human subjects to resort to self-experiment. The scientific enthusiasm which led many persons to submit to syphilitic and chaneroidal experiment has either died out or fears too serious consequences from the virulent pus of gonorrhœal urethritis.

In the face of these and other difficulties, it would seem that the degree of certainty required by modern medicine can be best reached by careful, candid, and persistent clinical research; and if a comparison is to be made with a view of differentiating specific and non-specific urethritis on the grounds of the clinical course of the disease, it is but fair that only cases of first gonorrhœas should be taken into consideration.

In our experience, the course of gonorrhœa in urethræ never before the seat of disease is the same in each and every instance, and is so characteristic that the nature of the inflammation is readily inferred from it alone. Its whole clinical course is different from that of simple inflamma-

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\* Read before the American Association of Genito-urinary Surgeons at its second annual meeting at Washington, D. C., September 17, 1888.

tion in the severity of its symptoms and in the complications which supervene—such as chordee, epididymitis, parenchymatous prostatitis, gonorrhœal rheumatism, and in the almost invariable sequel, a chronic stage that resists all treatment, both general and local, with the greatest obstinacy. No insult to a hitherto uninfected urethra, no matter whether it come from instrument or chemical, or both, is followed, in our experience, by such phenomena as are manifested by gonorrhœa. One rarely, perhaps never, sees a prostatitis or cystitis of the neck follow upon a simple non-specific urethritis beginning at the front. Epididymitis is a rare complication of such disorders, and when it does arise it is generally brought about by traumatism of the deep urethra, such as that caused by external urethrotomy.

Gonorrhœal rheumatism, though comparatively rare in proportion to the frequency of the parent disease, is indisputably peculiar to gonorrhœa, as well as distinct from other forms of rheumatism, as is shown by its resistance to treatment which ordinarily affects other forms favorably, and also by the improvement which follows treatment tending to benefit gonorrhœa. In opposition to this picture is to be placed the fact, abundantly verified by our observations, that a simple urethritis never becomes chronic, even though its course is of such severity as to produce stricture, which stricture is generally unaccompanied by discharge or pain, or other sign of inflammation, until it materially interferes with emptying the bladder or urethra; again, urethræ narrowed in any part of their course may go for the longest time without giving their possessors anything to complain of in an inflammatory way, if only they remain free from specific infection. Instances of the truth of this assertion are to be found in cases of traumatic strictures and in those adults with congenitally narrowed meati, who, having contracted their first gonorrhœa, come before us, and from whom no history of former urethritis can be elicited, and who were not even aware of the fact that the almost totally occluded meati were otherwise than normal. Cases of traumatic strictures in uninfected urethræ have, in our observation, almost no history of urethral inflammation and discharge, the chief, and frequently only, complaint being of the disturbance with the bladder. That one of the cardinal points of specific diseases (a period of incubation) has been denied gonorrhœa by some recent writers we are fully aware, but, confining the assertion to first infections, our observation of several hundred cases clearly convinces us of the justice and truth of the claim, as well as of its constancy, not one case diagnosticated as gonorrhœa by the microscope in urethræ never before infected having presented symptoms before the third day, and distinct manifestations often being delayed until the ninth or tenth day after exposure. If clap is a specific disease and due to the development of the germ locally, the first manifestation of

the activity of the infection should begin at the point of inoculation and spread thence in other directions, either along the surface of the mucous membrane or into the deeper structures. Our cases of first infection have been closely watched in order to ascertain whether any exception to this course of the disease existed, and we have failed to find a solitary case wherein the inflammation did not begin at or near the meatus and extend to a greater or less distance into the urethra. Very rarely we have observed an apparent extension over the preputial surfaces; but in the majority of these cases even the most careful means of prevention did not suffice to more than measurably prevent extension backward of the inflamed areas.

For a long time we have observed that those cases which, upon irritation from instruments, chemicals (injections), or altered conditions of urine, presented symptoms of inflammation of so high a grade as to be indistinguishable from gonorrhœa, occurred in those persons who presented histories of previous infections. Since we have been able to identify the gonococcus by the microscope, observation became more accurate, and in all these hitherto puzzling cases we have been enabled to determine the existence of that micrococcus in the discharge, showing that, so far as our clinical experience goes, this germ is playing a very important rôle in determining the degree of inflammatory action. If the germ was not discoverable (on account of scantiness of discharge) in the beginning, it became so as the inflammation rose to such a height as to render the pus abundant. In some cases where the organisms could not be found, either in the drop squeezed from the meatus or in the shreds washed out of the urethra by the first ounces of the urine, it was possible to identify them in the purulent drop which followed the conical steel sound up from the deeper parts of the urethra. On the other hand, we have noticed some cases in which the gonococcus was present in scant amount, which neither instrumentation, chemical irritants, abuse of food and alcohol, or excessive venery caused to inflame unduly. In other words, we found the gonococcus in all those cases where the degree of inflammation ran high; but the inflammation did *not* run high in all the cases where the gonococcus was to be found.

Of cases wherein an old or latent gonorrhœa, or a gonorrhœal patch deeper down in the urethra of the male, was lit up into an acute or sub-acute stage, with tendency to spread both forward and backward, with all the accompanying symptoms of increased pus discharge, we have seen an abundance; but in no case have we observed—where observation of both parties was sufficiently accurate to be of real value—a simple vaginitis or urethritis beget in another a condition even of simple inflammation, much less a condition that resembles a gonorrhœa. In the following synopsis of Case I it will be observed that the conditions for setting up a urethritis



in the male from non-gonorrhœal vaginitis were exceptionally good, but they failed nevertheless:

CASE I.—Two weeks after the wife had her uterus curetted by a gynæcologist an intense vulvo-vaginitis set in from unknown cause. The purulent secretion from the vaginal wall was examined four times without finding specific micrococci. On the fourth night of the vaginitis the husband, after copious libations of brandy and champagne and excesses in smoking and eating, has intercourse with the wife. Fearing he has impregnated the wife, he comes in alarm, and, being watched for several weeks, fails to show more than a slightly reddened meatus—never an inflammation.

The position of the sexes is reversed in the following:

CASE II.—A gentleman having extensive urethral strictures, and a chronic, tolerably abundant, gleety discharge which is purulent, is watched for more than a year. Repeated and careful microscopic examinations are made without finding at any time a gonococcus. He marries, and, though maintaining normal sexual relations with the wife, no gonorrhœa or even vaginitis of any kind is set up in the wife.

A comparison of these with the two following cases will give a clear idea of the results of our observation of the rôle of the gonococcus as the pathogenetic factor:

CASE III.—A young man comes with chronic gonorrhœa, which has been treated in Europe and America unsuccessfully, and is of two years' standing. He is treated by all means known to us with the result of reducing the discharge to such a degree as only to be manifested by a drop of pus that follows the conical steel sound up from the bulbous sinus. This drop always contains the gonococcus. In spite of the most earnest protest, he marries. Three weeks afterward we are called to attend his wife. She has violent gonorrhœal vulvo-vaginitis, with, later on, development of endometritis and pelvic cellulitis. Gonococci in vaginal discharge.

CASE IV.—A young physician comes with gonorrhœa of eighteen months' standing, which has caused the postponement of his marriage for one year. Discharge reduced to an occasional drop of pus in the morning, but the condition always aggravated and discharge increased by indiscretions in eating, drinking, or dancing. Disregarding protests, he marries. Two months later we are called upon to attend his young wife, who, we find, has been under the care of an able gynæcologist for five weeks. She has endometritis and pelvic cellulitis, and the vaginal discharges show abundant gonococci.

*Duration of the Disease.*—Formerly, when observations were made having regard to this point, the condition of the mucous membrane and the secretion of pus alone were relied upon to determine the question. When the "morning drop" and "gleety discharge," the redness and turgescence of the mucous membrane and its irritability, had disappeared,

the case was generally regarded as cured. Statistics based on any such crude standard are now recognized as being vicious and misleading in the highest degree. Judged by this standard, our observations would fully justify the statement ordinarily made that the average duration of the disease was from six to eight weeks. Recognizing, however, the all-important part played by the gonococcus, and believing from observations that so long as the urethral discharge contains that germ the case was still one of gonorrhœa, our observations would be very far from warranting any such statement. Indeed, more scientific and hence more accurate methods, along with increased knowledge of the disease, lead rather to the belief that in very many cases it is as difficult to say when gonorrhœa ends as it is to say when syphilis is cured. Our plan of determining the point has been as follows :

When there was no longer a drop of pus to be squeezed from the meatus for microscopic examination—when the patient could no longer bring a “morning drop” on a glass slide or on the cork of a small phial, for the same purpose—we passed a conical steel sound into the deep urethra, and, upon withdrawing it, we generally find, for a long time after the disease makes no other show of its existence, a drop of pus. This drop often contains the specific micrococci long after the gonorrhœal shreds of Ultzmann and the purulent strings washed from the deeper parts of the duct have ceased to show it. When these have all been interrogated and the micrococci found wanting, is the disease then cured? We would hesitate long before affirming it to be so, and we have good grounds in observation for this hesitancy. We have repeatedly observed cases where the specific micrococci would disappear from the most persistent search and reappear after an apparent absence of a week or two in the purulent drop squeezed out of the urethra by the sound, and again disappear, only to return again without assignable reason. The meatus and the mucous membrane of the anterior urethra were, to all appearances, normal in many of these cases, and only an extra redness, with some dullness of luster in the bulbous sinus, was shown by the endoscope. It is to be noted that the very small amount of pus secretion, coaxed out with difficulty, and the characteristic micrococci, were the only, or nearly the only, symptoms indicative of a disease capable of being communicated to another; for that it is capable in this stage of infecting another we have abundant evidence. The following case of chronic gonorrhœa, which has alternating periods of activity and repose, well illustrates the point at issue :

CASE V.—R. W. M., aged twenty-six, comes from Georgia with chronic gonorrhœa of a years' standing. His chief complaint is of neuralgia of the deep urethra. He believes his gonorrhœa is well. There is no discharge save a pearly drop of mucus in the morning, and a few “gonorrhœal shreds” in the first ounces of urine. His meatus has been slit almost to a hypospadias

and No. 32 F. sound passes easily into the bladder. Its withdrawal is followed by a large drop of thick pus, which, being stained, shows gonococci in a moderate amount. He is treated by us for eleven months and carefully observes directions, remaining, at our request, five weeks of this time in a hospital. All known methods are resorted to to cure this intermittent discharge of gonorrhœal pus without favorable result. Both pus and gonococci will disappear for a space of three weeks. His hopes rise. The sound will one day be followed by a drop of gonorrhœal pus, and he is again in the depths. Mild astringent injections act best with him, but silver nitrate always increases the pus and hastens the appearance of the gonococci. Douching the urethra and "retrojection" with hot bichloride solutions effect nothing. The stock of tonics is exhausted with no avail. Whatever increases urethral irritation increases the pus and determines the reappearance of the germs. At some point—almost certainly in the bulbous sinus—the gonococci have an extra urethral breeding-ground, perhaps in a mucous follicle or, more likely, in a small abscess cavity under the mucous membrane which alternately fills and bursts to close and fill again. But the gonorrhœal pus does not appear to be capable of inoculating the anterior portion of the duct. At the end of the tenth month of our observation the patient falls from grace, sins with a woman, and is again the possessor of an acute gonorrhœa, which begins at the meatus on the sixth day after contact and travels backward down the duct. At the end of the eighth week this fresh attack has subsided to the old condition. The patient's health being now at a low state, he is given cod-liver oil and hypophosphites, and he is advised to leave the urethra alone in the hope that the germ, now apparently localized, would shortly exhaust the soil and cease to become again active. Four months later he leaves for the South, still possessed with an intermittent pus discharge showing gonococci.

*As to its Chronicity.*—The greater number of gonorrhœas become chronic, and they do so despite conditions which would insure a return to health from ordinary non-specific inflammations. Treatment does not prevent this tendency in a majority of cases. Topical applications, whether they be begun at the commencement of the disease or only at the beginning of the declining stage, while they may and often do in the latter stage bring about an improvement, do so only by removing the effects of the specific poison upon the tissues; but they do not remove the cause of the disorder.

These cases, taken as they come, no matter what the social condition or habits of the patient, or the manner or kind of treatment, resulted in a majority of cases the same. After a time, varying from six to nine weeks, the chronic state was reached, and this state persisted, resisting all treatment. Though the discharge was diminished in many cases to the "morning drop" of the Germans, and in some modified to a mucous discharge, yet was the presence of the gonococci demonstrable in the first; and the second, by the slightest indiscretion on the part of the patient or

by irritation through instrumentation at the hand of the surgeon, changed into a purulent discharge containing the virus the contagiousness of which was, unfortunately for the victim, only too manifest by the infection, in several instances, of innocent parties. This stage of gonorrhœa may continue for years. Among these cases there were some in which the patient gave a history of a discharge from the urethra for as many as sixteen years, and in the majority of them there were no strictures. Dr. Noeggerath mentions three cases which lasted for ten, eleven, and fourteen years, respectively. Neisser also reports cases that have continued as chronic for as many as eight years. While there is an element of uncertainty as to the condition of the patient under observation being due to an infection so many years before, owing to the fact that he has not kept himself aloof from possible chances of subsequent infections, in many instances the history the patient gives of his behavior, together with the behavior of the disease, places beyond a reasonable doubt the inference that his disorder is due to first infection many years before. If gonorrhœa can remain for one year in a semi-active condition, we see no reason to doubt its doing so for many more. We have ample proof that the germs of this disease may exist in the tissue surrounding the urethra, with just enough activity to allow of their presence being demonstrated by a discharge of a drop of muco-purulent matter in the morning upon rising, and without giving the patient other cause for complaint, from one to four years in persons who have not given themselves a chance to become recontaminated. These patients present themselves with what we believe is a relapse from the chronic to the acute or subacute stages. We are led to think so from the fact that in these cases the symptoms are referable in the beginning entirely to the deeper parts of the urethra, and may begin in a few hours after excess either of venery or drink.

In many cases chronic gonorrhœa passes into a stage of perfect quiescence, during which there are no symptoms to disturb the patient, no irritability or discharge. This is the latent period, and it may obtain for years. Finally, some unusual excitement of the parts renews the activity of the germs; they multiply; the tissues again become irritated and inflamed under the action of the poison, and we have acute or subacute gonorrhœa—not a new attack, as is often supposed, but the old case relighted. Most of these attacks begin in the deeper parts of the urethra, for it is in these parts that the disease lingers the longest. These relapses seldom give the patient the discomfort that the first clap gives, and it is to this fact that we attribute the origin of the expression that they “would rather have the clap than a bad cold.” These attacks, as a rule, subside quickly under proper treatment, and all goes well until, under aggravating conditions, the virus-producing germs are rearoused. The ease with which these attacks are overcome, together with the mis-

taken idea that they are new cases, has led to the belief, popular with the laity, and indeed with many physicians, that a clap ought to be cured within ten days or two weeks. We believe that in this period of quiescence or latency the germ lies buried beneath the uppermost layers of epithelium, for it has been demonstrated by Bunn that the gonococcus penetrates the epithelium, into the submucosa, finding its way into the lymph spaces. This latency of gonorrhœa is brought about, it seems to us, by a partial exhaustion or modification of the soil in which the germs are situated. Any cause that brings about a fresh supply of the material upon which they live may cause a renewal of activity in them, and thus we have a relapse.

Thirteen hundred and ninety-four of the cases upon the records of which this paper is based were seen by us in dispensary practice; hence the observations are not of a character to justify the drawing of definite conclusions as to the average duration of gonorrhœa after the statistical method. Equally unreliable, in our opinion, are deductions drawn from the statements of patients, into which enters the ever-present and important question of the liability to reinfection which they incur. The whole literature of this disease is overrun with this element of error, and we do not desire to add to the already large stock of misinformation. We can do no better, therefore, than to record our concurrence in the generally expressed opinion of clinicians that when treated by the so-called "methodical" method, the great majority of cases of gonorrhœa apparently get well in from six to eight weeks. This we find most frequently occurring when all local treatment is abstained from in the increasing and stationary stages of the disease, and is reserved for the decreasing or subacute conditions, every effort being made to limit the inflamed areas to the anterior portion of the duct.

All treatment of the disease naturally falls under one of the following heads:

1. Topically applied germicides.
2. Locally applied remedies intended to improve the condition of the mucous membrane (generally astringents, used with the view of lessening pus discharge and reducing congestion).
3. Germicide remedies given internally, with the view of saturating the blood and secretions flowing over the inflamed surfaces and nourishing the infected tissues.

Chief among the local germicide methods stands the so-called "abortive." Prior to the establishment of the germ theory of the malady we made the usual efforts to abort gonorrhœa by the local application of strong silver-nitrate solutions. This not only failed us utterly, but aggravated the complaint in a marked degree; complications increased and we abandoned the method. Becoming convinced four years ago that

we had to deal with a germ disease, we again resorted to the local germicide treatment, choosing as the most powerful and the most promising the mercuric bichloride and silver nitrate, the former in strength ranging between 1 to 300 and 1 to 5,000, the latter in one quarter of a grain to ten grains to the ounce, copiously douching the urethra by means of appropriate apparatus. With these means we not only failed to reduce the number of gonococci, but drove the disease lower down the duct. With the solution, by means of which we hoped to destroy the germ, we apparently picked it up and transported it, unimpaired in health and vigor, to another surface and there inoculated it. Moreover, we are of the opinion that the conditions necessary to the germicide treatment are not attainable in these cases. These conditions are, first, contact of the remedy with the germ, and, second, contact for a sufficient length of time to destroy its activity. The two remedies under consideration not only failed to come in contact with the germ, which rapidly penetrates the membrane, even to the submucosa—thus failing to answer the first condition—but form insoluble albuminates with the superficial cells and so excite antagonism of the elements overlying the untouched and unimpaired morbid germs.

Our records show twenty cases treated by the abortive method of Wellender and Boekhart with the sum-total of one success. All the cases were first infections and the disease limited to the navicular fossa. The micrococcus was demonstrated in each, and suppuration had just developed. The infected part of the urethra was thoroughly scraped until it bled, and this was followed by applications of silver nitrate and cupric sulphate, all the scraped area being brought well in contact. The pain which this operation inflicts is very great. The success of this mode of treatment depends entirely upon the perfect removal of the germs. As they rapidly penetrate the upper layer of the epithelium, down upon and into the papillary layer, this is a difficult task; and even if the upper layer is thoroughly removed and the parts flooded with the most powerful germicide solutions, some of the germs will escape contact with the medicament. These remain just as potent for harm as ever, causing the disease to spread backward beyond the fossa and out of reach, as the method can not be successfully applied beyond the anterior part of the duct. The rapid penetration of the micrococci into the submucosa constitutes, in our opinion, the chief obstacle to success. With only five per centum of cures in cases especially favorable to the method, and considering the pain, inconvenience, and uncertainty of the procedure, we do not feel justified in continuing its application. These remarks apply to the treatment of the first stage, or rather to the very beginning of that stage, generally called the increasing stage of gonorrhœa. Our efforts in this direction teach us that the local germicide treatment is even less success-

ful in the second, or stationary, stage of the disease than in the other. In the stationary stage the disease has spread over a larger area, has gone further down the duct, and, above all, the poison has penetrated deeper into the circumurethral tissues, thus becoming altogether more inaccessible. Moreover, experience demonstrates to us that in the first and second stages all topical applications are harmful. Whenever we have submitted a considerable number of cases to this treatment we observed a more rapid extension of the disease, an increase in the complications, and a greater tendency to inveteracy. We have, therefore, again abandoned all local application in the first and second stages of the disease, reserving them for the last or chronic condition.

Our observations have, furthermore, led us to the conclusion that all topical applications which favorably affect the course of the disease do so by reason of their astringent influence upon the tissues in which the germs lie imbedded, condensing the medium and thereby retarding their reproductive activity. This beneficial result may be more apparent than real, since astringents also retard pus formation, and to that extent lessen the eliminative action of the mucous membrane. This treatment seems to be simply a method of influencing the soil in which the germs are increasing and multiplying, for we observe that any application which increases irritation is immediately followed by an increase in the number of pus-corpuscles and gonococci. It is only in the third stage, when the soil is impoverished and the germs reduced by partial starvation to a low stage of reproductive activity, that local applications seem to be of service; for at this stage condensation of the tissues means more than ever to the micrococci whose power to multiply is at a minimum. As a matter of clinical observation, it is at this stage that we find the mild vegetable and mineral astringents of the greatest service.

Of those remedies which, given by the stomach, appear to favorably affect the disease by saturating the blood and urine with their digested products, we still find the balsam of copaiba and the oil of yellow sandalwood by far the most efficacious. Where the stomach bears and digests them well, when they do not irritate the skin or kidneys, and can be pushed to the full degree of saturation, we observe the best results in the first and second stages of the disease. Whether these remedies, exhibited in this way, be called germicide in a proper sense, or whether, if they are so, they exert their influence through the blood, or by way of the urine, as it flows over the affected parts, is foreign to our present object, since we deal here only with results. We content ourselves with stating simply that we see no good reason for denying their germicide property. If future research shall demonstrate that they have this property, the inference would be natural that their power would be exerted more through the circulation than through the kidney, for there seems no good reason

to suppose that the urine is saturated to a greater degree than the blood, and contact from the blood with the germs imbedded in the submucosa is more direct and efficient. Thus we have the two conditions necessary to the successful application of a germicide—viz.: contact, and contact for a length of time, fulfilled in a high degree—a degree hardly attainable in the case of any local application to the urethra whatever.

Our conclusions are as follows:

1. Gonorrhœa is a specific disease.
  2. The gonococcus of Neisser is an essential ætiological factor.
  3. The abortive treatment is both inefficient and harmful.
  4. Local treatment of all kinds is not justified in the first and second stages.
  5. We recognize in the disease a marked tendency to persist in the chronic stage.
  6. The tendency to become chronic, and to persist, appears to be increased by the use of topical treatment in the first and second stages.
  7. The so-called "methodical" treatment—that is, the internal administration of remedies, combined with the proper hygienic and dietetic regulations—does most to shorten the duration of the disease.
  8. All local applications should be reserved for the third or declining and chronic stages.
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### A CASE OF NÆVOID ELEPHANTIASIS.

By B. MERRILL RICKETTS, M. D.,

Professor of Dermatology and Syphilography at Cincinnati Polyclinic, Lecturer on Plastic Surgery at Miami Medical College, and Visiting Dermatologist to the German Protestant Hospital.

IT is almost two years since a farmer, forty years of age, came under my observation with the history of having had this disease from infancy, there being but little if any change until adult life was reached, when the growth began to increase at a greater ratio than the body, he having attained his present size at that age.

He is a bachelor of forty-two, of irregular habits, occasionally indulging to excess in the use of alcoholic stimulants. However, his general health is good, and he leads the life of the average farmer and horse-trader. The skin is very much discolored, having the color of the ordinary wine-mark so often met with at the time of birth. This discoloration extends over an area corresponding to a line drawn from the lower margin of the wing of the nose to the top of the ear on either side, and involves the whole integument of the neck as low down as the clavicle. There are a few scattering hairs upon the cheeks, while there are none upon the upper lip to the left of the median line.



Those hairs to the right of the median line of the upper lip are about one third in number to those found upon the average lip.

The skin of the nose is entirely free from any abnormal thickness or discoloration, while the ears suffer from the discoloration alone.

The skin upon the chin has become so heavy from increased thickness that the lower lip has been pulled down and has become a part of it—so much so that the six front teeth and corresponding gums of the lower jaw are constantly exposed—no trace of it to be seen.



There are no hairs whatever upon the integument of the chin, the whole growth having the appearance of a cedar-apple in shape and almost in color.

The openings of the hair and sebaceous follicles are depressed, giving to the skin a pitted appearance.

A few nodules, varying in size from a split pea to a small hazel-nut, can be seen here and there upon the cheeks and chin. He has never complained of pain, and but little discomfort except during the excessively

cold weather; some difficulty is experienced in keeping this portion of the face warm.

The skin shines and has the appearance of being intensely stretched. It feels cool to the touch, the temperature being from one half to one degree lower than upon the forehead or about the eyelids.

He has occasionally felt slight swelling about the neck, which I attributed to lymphatic disturbances. The glands about this locality have been more or less involved, especially during the last twenty years.

He thinks that the glands of the neck are larger than they were in his younger days, and he says he is confident that they are more sensitive than at that time. He also at times complains of myalgia of the neck, mostly, however, after overexercising or taking long drives.

It seems that the disease in this section of the country is exceedingly rare, as I have not been able to find the report of any such case.

While attending the International Medical Congress at Washington, D. C., I had the pleasure of showing the photograph to Unna, of Hamburg; Justus Andeer, of Munich; Thin, of London, and many others who have great clinical advantages, but none had ever seen a case where the disease had appeared in a similar position.

93 EAST FOURTH STREET.

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 187TH REGULAR MEETING.

DR. E. B. BRONSON, *in the absence of the President, was elected Chairman.*

**Annular or Circinate Erythema.**—DR. ALLEN presented a case of this affection in a patient the subject of tertiary syphilis, which he regarded as in some way connected with the specific disease. The patient had been treated about two years ago for secondary manifestations, and during the past year has had occasional symptoms of syphilis, especially a grouped papular eruption upon one side of the nose which constantly recurred but soon disappeared again under mercurials. Twenty days ago the patient first noticed bright rings of various sizes upon the thighs and legs, and when seen three days later some had become as large as a fifty-cent piece. They were symmetrically distributed and confined to the lower extremities at first, but are now present upon both forearms, where are also to be seen more or less rounded erythematous blotches. The trunk shows no lesions. The ringed margin is slightly elevated and the center very slightly scaly. There has never been the least itching in the lesions, according to the patient's state-

ment. No mercurials or iodide had been given for two weeks before the eruption appeared, and the patient says he has taken no other medicine.

DR. SHERWELL was uncertain about the character of the case. It did not look like a syphilide; it was apparently very superficial. He would like to exclude tænia and pityriasis maculata et circinata before he would pronounce the case to be syphilitic.

DR. ROBINSON said that, from the history of the spread of the disease and from the fact of its being located so superficially in the upper layers of the epidermis, he would diagnosticate the case as one of ringworm. Of course the microscope would decide the question of its being the latter disease.

DR. KLOTZ said that it reminded him of erythema multiforme, and its location upon the extremities was in favor of this. It could possibly be caused by some toxic substance, medicinal or otherwise.

DR. ALLEN observed that the patient was not taking any medicine at present. He was treating him for stricture.

DR. BULKLEY could not see anything specific in the acute lesions on the legs. He did not think it was ringworm, on account of the rings clearing up in their centers without scaling. The spread of the disease was more like that of an erythema; not necessarily from drugs. It is probably a case of erythema multiforme. In this connection he would ask, Is erythema multiforme connected in any way with any possible nerve lesion of syphilis?

DR. ROBINSON would call attention to the fact that the lesions had lasted two weeks, and would ask Dr. Bulkley if he had ever seen the lesions of erythema lasting so long?

DR. BULKLEY and DR. FOX had seen them do so.

DR. BRONSON did not regard the lesions as syphilitic, and was strongly inclined to pronounce them to be those of ringworm.

DR. ALLEN asked if it was customary for ringworm to spread so much over the body in so short a time, involving the arms some two weeks after beginning on the legs?

DR. BRONSON would answer, Yes. It was quite common for herpes tonsurans maculosus to become general.

DR. FOX suggested that the symmetry of the eruption would decide between erythema multiforme and ringworm. He had not seen this case, and so perhaps should not enter into the discussion.

DR. ALLEN said that there was such symmetry. He would say that ever since the man had been under his care he had complained of a peculiar feeling in his legs; the left leg trembled so that he could no longer climb a ladder. He also had nervous twitching in his legs. There was probably some nerve element in the case. It may not be a case of syphilis, but he would regard it as one closely allied to syphilis.

**Eczema of the Nipple.**—DR. SHERWELL presented a case of this disease which, when first seen by him six weeks ago, resembled Paget's disease. The patient was a young girl, seventeen years old. When first seen, the nipple was affected with an eczema that was moist, and had a peculiar fungate look. It was very obstinate to treatment, but within the past week it had become much better under a very mild ointment of resorcin and salicylic acid. There was infiltration, but no induration. He was apprehensive that it

might later take on a decided change, and assume the form of Paget's disease.

DR. ROBINSON regarded the case as it presented itself to-night as one of ordinary eczema, though, of course, he could not make a positive diagnosis to that effect in the light of Dr. Sherwell's history of the case.

DR. BRONSON said that he had seen only one positive case of Paget's disease, and in that the eczema was markedly circumscribed, of a glazed look, and would not skin over. There was also a constant retraction of the nipple. It looked like eczema madidans. The case now before us was more diffuse, and he would not regard it as one of Paget's disease.

**Syphilis resembling Psoriasis.**—DR. ROBINSON showed a case of this affection occurring in a man who gave a purely negative history. On the arms there were a number of patches that bore so strong a resemblance to psoriatic patches as to be difficult of diagnosis without other symptoms of syphilis. The eruption was very itchy.

DR. SHERWELL would regard the case as one of psoriasis on a syphilitic ground—a pseudo-psoriasis.

DR. ROBINSON called attention to the fact that in this case the bleeding points, supposed by some to be indicative of psoriasis, could be obtained very easily by scratching.

**Psoriatic Eczema.**—DR. BULKLEY presented a case of this affection with the following history: Pat. M., aged twenty-one; occupation, porter. The disease began seven weeks ago on the inside of the right tibial region. Two or three red spots appeared, covered with a whitish scab. At first they were circumscribed; then they became confluent. The same eruption then came on the corresponding part of the left leg. The eruption spread over both legs and thighs, and after a time involved the hips. Suddenly a diffuse redness began on the knees and inside of the thighs, with scabs and crusts. Then the elbows were affected with psoriatic spots, and the arms and forearms, and other parts of the body. On the left side of the chest there is the same diffuse redness as on the legs, with here and there circumscribed lesions. The eruption on the thighs and chest appears something like that of eczema of papular character.

DR. ALLEN objected to the name "psoriatic eczema," as it was apt to be confusing.

DR. KLOTZ believed the case to be a combination of eczema and psoriasis.

DR. BRONSON asked what Dr. Bulkley would call the lesions on the chest.

DR. BULKLEY, in closing, said that he used the name to indicate an eczema with some relation to psoriasis. The case might continue as one of either of the two diseases. The lesions on the chest were accounted for by the mixture of the two diseases.

**A Case for Diagnosis** was presented by DR. ALLEN: M. H., fifty-two years of age, had psoriasis for the first time fifteen years ago, and since then has had frequent attacks which come out in the winter and get well in summer. Last April he left the Charity Hospital entirely free from eruption after a short course of treatment. In September the eruption reappeared, and he has been at the hospital most of the time since. On admission, nearly the whole body was covered with psoriatic patches which in places had become

confluent and were quite itchy. He was treated with chrysarobin and anthrarobin. The former, being of more benefit, was mostly employed. On February 12th, Fowler's solution was begun in three-drop doses, and chrysarobin paint, 3 j to 5 j, was applied to the few remaining lesions upon the chest. On February 17th an acute inflammatory eruption, beginning as vesico-pustules about the hair-follicles, appeared, and rapidly spread over the whole body, becoming confluent upon the chest and back, drying into thick, dry, yellow scales, beneath which the skin was bright-red, painful, and infiltrated, appearing like an eczema without exudation. Papulo-pustules are present upon the face, and the scalp is covered with thick crusts. The backs of the fingers are puffed up and covered with deeply imbedded tense vesicles, suggestive of rhus poisoning. For the past week the only treatment has been a soothing dusting powder.

DR. FOX said that he believed we were too apt to lay too much stress in diagnosis upon the appearance of the scales. He believed that the main diagnostic feature of psoriasis was its recurrence year after year. He regarded the case as one of psoriasis. The smooth papules that were present were not psoriatic, but were probably due to some application to the skin. He had seen similar ones develop in the neighborhood of psoriatic patches that he had overstimulated.

DR. ROBINSON said that it was impossible to make the diagnosis from the history. The pustular lesions, beginning as vesicles, were not psoriatic, and may have arisen from some application.

DR. KLOTZ would regard the peculiar lesions as due to treatment.

DR. BULKLEY regarded the case as one of irritative dermatitis due to treatment.

DR. BRONSON had seen the case before in the hospital when it was a true psoriasis. He would regard the pustules as a drug acne from chrysarobin.

DR. FOX would object to the use of the term acne not only in this case but also in other cases, such as those from the use of tar or bromide. It seemed to him better to regard them as pustules, and to speak of them as pustules from tar or bromide. They had nothing to do with acne.

DR. ALLEN said that he had shown the case as it differed from any other case of dermatitis from chrysarobin that he had ever seen. By daylight the lesions could be seen starting around the hair-follicles.

**An Atrophic Condition of the Skin of the Legs.**—DR. BULKLEY showed a case of this condition: Jacob M., aged forty-five; liquors. Patient came on account of varicose ulcers of the left leg that he had had off and on for thirty-two years. He does not remember when the peculiar condition of his legs began, but thinks it must have been some fifteen years ago. The entire upper part of the left leg, beginning about three inches below the groin, is atrophied, the skin being very thin, red, dry, and scaly; hardly any subepidermal tissues to be felt. The veins show with great distinctness through the skin. The atrophied parts are sharply defined by a line at the gluteal region above and at the knee below. The same atrophic changes are beginning on the other leg at the knee. An erythematous blush seems to precede the atrophy.

DR. KLOTZ regarded the case as one of sclerosis, beginning in the veins

but later affecting the cutis. He thinks that it could not be put under any one recognized class of disease, though it had some features of *lioderma*.

DR. BULKLEY believed that there was some spinal disease underlying the process.

**Erythema Multiforme.**—DR. BULKLEY then presented a case of this disease with the following history: Rosa L., aged seventeen, domestic. She was first seen on June 13, 1888, when she had *pediculosis capitis*, with *impetiginous* lesions of the cheeks and chin, for which she received appropriate treatment. On July 6th the patient returned with a very marked *erythema multiforme* of the dorsum of the hands, extensor surfaces of the arm, face, neck, legs, and insteps. The lesions were to a great extent vesicular. She said that she had a similar eruption the year before. Her general health was good. Under iodide of potassium and *nux vomica* her condition improved, but at the end of a fortnight her body became covered with a similar eruption, but of intensely pruriginous character. The vesicular eruption was confined to the hands, arms, and legs. Headache and pain in the joints were also complained of. On September 10th, her condition remaining unimproved, she was admitted to the hospital and given alkaline baths, followed by *ungt. sulph. lact.* Under this treatment she improved, and was discharged as cured in about fourteen days. On October 5th the patient was readmitted with a recurrence of the entire former condition, and again discharged cured in three weeks. She was out only three days, when, on the 26th of October, she came in with a relapse. She was now in hospital for over three months, during which she had an outbreak of acute pustular *eczema* of the face, and *blepharitis marginatus*, the original affection slowly improving, but showing a strong tendency to relapse. *Amenorrhœa* was present but yielded to treatment. On February 9th she left the hospital, and on the 15th she had a violent outbreak of congested papules with slight vesiculation and much itching upon the face, back, arms, and fingers. Some of the papules are torn, and some of those on the back of the hands are of the same color as the surrounding skin.

DR. SHERWELL thought that at present it looked like a *lichen simplex*. Judging from what could be seen to-night, he did not think the disease was an *erythema multiforme*. He would suggest in treatment *Startin's* mixture with wine of *colchicum* or *nux vomica*.

DR. ROBINSON said that the disease appeared to-night as a follicular *eczema*, depending upon some agent acting from within. In treatment he suggested lithiated potash and diet.

DR. BRONSON protested against the use of the term *eczema* in this case, as all of its essential characters were wanting. It was not diffused, but localized, and its vesicles were much larger than those of *eczema*.

DR. ROBINSON said that he believed we would always find exactly similar lesions about the majority of the patches of *eczema*. He would call it *eczema* because the epidermis that dipped down into the hair-follicles was the same as that of the skin, and was the first to react to an external irritant applied to the skin, and probably would do the same with irritants acting from within.

DR. FOX spoke of a somewhat similar case he had met with in a young

woman who also worked in a cigar factory. He had had her under observation for years, during which he had used all sorts of remedies, but the disease continued in spite of treatment. He had been at a loss to give the disease a name. In his experience, follicular eczema was a disease limited to the inside of the thighs.

**Chancre of the Ring Finger.**—DR. ALLEN presented a case of this unusual localization of the initial lesion of syphilis in a married man thirty-five years old. The history given was that a pimple had appeared over the knuckle and he picked it with a pin, after which it grew larger and was finally lanced at a hospital, but no pus came out. One week after it was opened and five weeks after it was first noticed an eruption appeared upon the body and face, and when Dr. Allen first saw the case, about a month ago, a papulo-tubercular eruption, of which evidences still remain, was very characteristic, and mucous patches are present in the mouth. Attention was called to the extreme enlargement of the epitrochlear gland upon the affected side, and the slight enlargement of the glands in the inguinal region. There was no sign of a primary lesion upon the genitals or elsewhere upon the body, and the patient positively denies exposure. The primary lesion had characteristic induration, which now, after a week of inunction cure, has somewhat softened.

**Dermoid Cyst.**—DR. ALLEN presented a pathological specimen of the ovary which had been removed from a patient of his by Dr. James R. Goffe one week before. The tumor contained a large mass of curled-up hair, about a pound of sebaceous matter, a number of teeth growing from the cyst-wall, and some tissue which showed skin elements and from which hair could be seen growing. The patient had made a good recovery, although the tumor had been very adherent to the intestines and omentum, and much of the latter had to be cut away with it.

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## Correspondence.

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### LETTER FROM THE EDITOR.

#### MATTERS OF DERMATOLOGICAL INTEREST IN MEXICO AND CALIFORNIA.

DEAR JOURNAL: I have thought that a few jottings of my observation of matters medical in Mexico and California may prove of interest to your readers. From a medical standpoint Mexico has always been a sort of *terra incognita* to the profession of our country, but, with the improved facilities of communication and the commercial intercourse which has sprung up within the last few years, Mexican affairs and institutions have assumed a new interest and importance.

Mexican medicine is essentially Gallic in its origin and tendencies. A large proportion of Mexican physicians have been educated in Paris, and French is the language of most of the medical text-books. The impress of French doctrines and traditions is plainly evident in methods of practice,

which present nothing distinctive or *national* except, perhaps, the employment of certain therapeutical agencies, derived from their indigenous materia medica, which are not in general use with us.

In the city of Mexico, with its 350,000 inhabitants, there is quite a large number of hospitals, the accommodations of which are hardly sufficient for the numerous sick that crowd the wards. The city is reputed to be very unhealthy, due partly to its situation below the level of the surrounding lakes and lack of drainage, but largely to the miserable diet, the overcrowding, and the bad hygienic conditions under which the poorer classes live. The Military Hospital is the most important and best equipped of any in the city, but the condition of the hospitals generally, in respect to cleanliness, comfort, and sanitary arrangements, does not favorably impress one accustomed to our New York charitable institutions. Owing to the lack of a sufficient subsidy on the part of the Government, the wards are but poorly supplied with beds and clothing, and present a poverty-stricken aspect.

There are no special wards for diseases of the skin in any of the hospitals, the patients suffering from this class of affections being distributed through the general wards of the various civil hospitals. While one may see here and there an interesting case of cutaneous disease, there is but little of strictly dermatological interest to be observed. There are no statistics accessible upon which one can base an appreciation of the relative proportion of different forms of skin disease. Ringworm I should judge from my observation to be quite prevalent, this disease among the Mexicans being clearly a rapid and exaggerated development. I saw cases in which the disease, beginning on the inner surface of the thighs as an eczema marginatum, covered the entire scrotum and penis and extended up over the abdomen and trunk in immense gyrate circles. The treatment generally employed is a strong solution of salicylic acid in alcohol, which is painful, but said to be promptly efficacious.

**Venereal Diseases.**—Mexico is not mindful of its morals, and, as may be imagined, venereal diseases are very prevalent. A number of hospitals have special wards for the treatment of this class of affections. In Mexico, as elsewhere, the soldier falls an easy victim to the charms of Venus, and, as a consequence, syphilitics represent quite a large contingent of the inmates of the Military Hospital. The Hospital of San Andrés, under the directorship of Dr. Lavista, has special wards for venereal diseases, accommodating fifty to sixty patients. The Hospital de San Juan de Dios, which I also visited with Dr. Lavista, is especially devoted to the care of prostitutes. It has about two hundred and fifty beds, fifty of which are reserved for gynæcological cases not necessarily of venereal origin. In these several hospitals I saw quite a number of interesting cases. I was surprised to find such a large number of chancreoid, or *chancros blandes*, a proportion relatively much larger than exists in Charity Hospital, New York, and in marked contrast to the showing of the Paris hospitals, where chancreoid is almost extinct. Among several hundred cases of venereal sores which I saw in the Paris hospitals there were not half a dozen cases of chancreoid. Among the noteworthy cases may be mentioned a chancre of the root of the nose extending over the left upper lid and producing much deformity, several examples of precocious gummat-



ous nodes, and the remarkable pustular eruptions of the impetiginous variety which covered the entire face and head like a mask, as well as the greater portion of the body. From my observation of two or three hundred cases, I should conclude that syphilis was relatively a mild disease in Mexico, so far as its external manifestations are concerned. Most of the eruptions were of the erythematous and papular type. I saw no examples of malignant precocious syphilis, and but few of the deep destructive tertiary type.

Sclerosis and hypertrophy of the labia seem to be quite common among the prostitutes, in many cases assuming an elephantiasic condition. In one case there was an enormous hypertrophy of the right labium as large as a water-pitcher, extending down below the knees, the clitoris also being several inches in length and five or six inches in circumference. A history with photograph of this remarkable case was promised by Dr. Lavista.

There are no peculiarities of treatment of chancroid and syphilis practiced in Mexico worthy of mention, the treatment being essentially the same as that employed in Paris and elsewhere. A number of native plants as well as certain mineral springs, notably the Napo-chico and Santa Rosalia, are invested by popular tradition with remarkable virtues in the treatment of syphilis. It is needless to say that medical men do not share this enthusiasm, and place their chief reliance upon mercury and iodide of potassium. The treatment of syphilis by the hypodermatic method has been tried and abandoned.

I saw few cases of gonorrhœa in the hospitals, this probably due to the fact that most of the Mexicans of the lower class treat a clap with domestic remedies, seldom having recourse to a physician. They employ hot baths and rest until the acute stage is passed, and then use a tea or decoction made from native plants which have a reputation as antiblemnorrhagics. In this connection it may be said that in Mexico, especially among the lower classes, venereal diseases are not looked upon as *private diseases* in the same sense that they are regarded elsewhere. The existence of a gonorrhœa, for example, carries with it no sense of shame, but is considered rather in the light of a common cold or influenza, concerning which there is no motive for concealment from other members of the family.

**Leprosy.**—In the San Pablo or Juarez Hospital, which serves the purpose of a general accident hospital, a reception hospital for typhus fever and other contagious diseases, and also as a lazaretto, I saw a number of cases of leprosy. In Mexico the disease assumes rather the macular and anæsthetic types, the tubercular form being comparatively rare. Thus among eight women examined by me there was only one example of the tubercular variety. This was a most characteristically marked case in an Indian woman, a native of Vera Cruz, who thought she had contracted the disease several years before by washing the clothes of a leper. The seven other cases showed the characteristic deformity of the hands, with loss of phalanges of both hands and feet, with localized areas of anæsthesia, ocular lesions, etc. The ages of the patients were from thirty to fifty years, and the duration of the disease had been from two to seventeen years.

The most rigid inquiry into the antecedents of the patients failed to elicit any history of heredity or even of known contagion, with the exception, per-

haps, of the tubercular leper already referred to. I may say that while the hereditary nature of leprosy is generally admitted, a belief in its contagiousness by direct contact, proximity, or sexual intercourse does not generally prevail among the physicians in Mexico; at least they assert that well-authenticated proofs in support of this view are wanting. No attempt at segregation of the lepers is made by the authorities. Many lepers may be seen wandering in the streets, and their entrance into the hospitals is voluntary rather than compulsory.

In this connection the fact may be referred to that leprosy has existed in Mexico from the most remote times. The disease was prevalent at the time of the conquest, and the Conqueror, Cortes, established a hospital exclusively for those afflicted with the *Mal de S. Lazaro*. About twenty-five years ago the lazaretto was abolished, and since then lepers have been treated in the wards of the civil hospitals. Statistics fail to show whether the disease has been on the increase or not since the suppression of segregation, but many physicians assert that the disease is gradually decreasing.

Along the California coast the possible danger of the spread of leprosy is a matter of great interest and concern to the profession as well as the public. There is, of course, by no means a unanimity of opinion among physicians upon this subject. To those who believe that any leper in this country is a possible focus of contagion to every one with whom he may come in contact, the danger appears of the most threatening character, demanding the prompt and rigid segregation of all persons affected with this disease, as the condition of protection of the public health. By those who hold that the communication of leprosy is a matter of race, climate, and bad hygiene, possible only in certain conditions which do not exist in this country, no fear of a spread of the disease is entertained.

Unquestionably leprosy exists in this country to a much larger extent than is generally supposed. The recent paper of Dr. Blanc in the *New Orleans Medical Times and Journal*, in which he gives a report in detail of forty-two cases in New Orleans, was a surprise and a revelation to many who did not suspect the existence of that number of cases in the entire United States. This report did not include, of course, the cases at St. Martinsville and Bayou Lafourche. I visited the Têche River district on my way from New Orleans to Mexico, but had no opportunity of examining the cases in St. Martinsville parish, since they have already suffered a disagreeable notoriety and secluded themselves from observation. As is well known, leprosy has existed in this little center since the first settlement of the country by the Arcadians, but, as favorable conditions for its spread do not exist, it has been confined to a few Creole families.

In Los Angeles I met Dr. Orme, the efficient president of the California State Board of Health, and he courteously placed at my disposition the results of his inquiry into the existence of the disease in this State. He had sent out a circular letter to two hundred physicians, requesting each one to report all cases in his particular locality. He had received replies from sixty physicians, reporting a total of twenty cases of leprosy and two doubtful cases. Undoubtedly these figures do not represent the entire number that actually exist, since it is the custom of the Chinese, among whom leprosy most pre-

vails, to harbor and conceal their afflicted countrymen until the last stages of the disease.

In the Pest House of San Francisco there are at present six cases, all males, in one of whom, a negro, I could detect no positive evidences of the disease; of the number, two were Chinese, both exhibiting the tubercular form of the disease in a most aggravated degree. The remaining three were brothers, and natives of the Sandwich Islands; the father, a white man, perfectly healthy; the mother, a Hawaiian woman, formerly suspected to be a leper, but now, as I understand, exhibiting no evidences of the disease. The ages of the boys are seventeen, nineteen, and twenty, respectively; they all have undoubted manifestations of leprosy of the anæsthetic type; two have ocular lesions with the characteristic bird-claw deformation of the hands and fingers. In the eldest the first manifestation of the disease was observed when he was fifteen years of age, in the second when he was fourteen, and in the youngest also at the age of fourteen. I shall probably have an opportunity of examining the mother of these boys on the islands with a view of eliciting more definite information. Incidentally I may say that these boys are all improving under the method of treatment employed by Dr. Gato in the Leper Hospital of Tokio, Japan, and also by his son in the branch hospital for lepers at Kakaako, of which, with other matters of interest in connection with leprosy, I shall speak in my next letter from the Sandwich Islands.

PRINCE A. MORROW.

SAN FRANCISCO, *February 9, 1889.*

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## Book Reviews.

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*Atlas des maladies de la peau* (dermatologie et syphiligraphie). Par SILVA ARAUJO, Médecin de la policlinique générale (service de maladies de la peau et syphilis), Membre titulaire de l'Académie impériale de médecine, etc, Rio de Janeiro. Leuzinger & Fithos, Rio.

THE third fasciculus of this South American contribution to dermatology has been received. The entire space of this number is devoted to the consideration of elephantiasis, a subject with which the author shows great familiarity, and in the treatment of which he has achieved much success. The phototype plate represents six stages in the progress toward cure in a case of the tuberous variety of elephantiasis affecting both feet and legs. The disease had begun at the age of eleven, and the phototypes represent the gradual improvement which took place in the young man's condition between the ages of eighteen and twenty-four, while under treatment by electrolysis. The publication of this fasciculus has been delayed until the author felt that his experience had extended over a sufficient number of observations to have a scientific value. For ten years he has given much attention to the subject, and has observed over four hundred cases of this terrible disease which is so prevalent in these intertropical countries. The demonstration of the efficacy

of electricity for certain cases appears from Dr. Araujo's publication to be complete, but infallibility is not claimed for the method. Covering as this work does so large a number of personal observations, it surely is a most valuable addition to the literature of an interesting but still somewhat obscure disease.

C. W. A.

*On Gonorrhœal Infection in Women.*

A MONOGRAPH, by William Japp Sinclair, on this important subject, takes up 128 pages of the second number of "Wood's Medical and Surgical Monographs," February, 1889.

The social and moral consequences of the group of diseases produced by gonorrhœa in the female make this subject of the utmost importance to the general practitioner as well as to the specialist. The views as usually taught are often inadequate and frequently erroneous, and many classic works are silent in regard to dysmenorrhœa, pyosalpinx, sterility, and other recognized results of the virus. The author has written a very forcible protest against the tendency by some to regard the disease in women as a trifling matter, and has shown that its frequency and disastrous effects are not sufficiently realized. He regards the work of Noeggerath, which appeared in 1872, as marking the beginning of a new era in our clinical knowledge of the disease. Säger, who is perhaps the principal champion of Noeggerath's views in Germany, found that one eighth of nearly two thousand gynæcological cases treated in one year by himself were due to gonorrhœal disease, while out of three hundred and eighty-nine pregnant women one hundred were found to have a purulent discharge, and forty of the children when born suffered from ophthalmia neonatorum.

The great value of the gonococcus is recognized in the diagnosis of obscure cases. Although Hallier had discovered and described cocci occurring in gonorrhœa pus as early as 1869, Neisser is very properly accorded the credit of giving "the stimulus and guidance to workers in the same field," and the history of his discovery and the subsequent observations of others are passed in review.

The treatise of Ernest Bumm is regarded as the most important original work which has appeared, and is largely drawn from in the chapter on pathology.

The clinical phenomena of infection in its varied forms—urethral, vulvar, uterine, and tubal gonorrhœa, and its effects upon the ovaries—are considered at some length. A chapter is devoted to sterility as a consequence of this disease, and another to gonorrhœal puerperal fever, a rather new but important subject which needs further investigation. He is disposed to agree with Noeggerath that most salpingitis must be classified as gonorrhœal.

Gonorrhœa in a woman which has once passed beyond the uterus is regarded as an incurable disease, "whose miserable consequences may be sometimes palliated by operative gynæcology."

In uterine gonorrhœa, tincture of iodine is injected into the organ. The best local treatment in general is antiseptic. The chapter on prophylaxis is somewhat disappointing, for a disease so often innocently acquired and which leads to such sad results should, above all things, be prevented if within the

possibilities. The work is one of much interest on a most important subject, and will undoubtedly be widely read. This number of the "Monographs" also contains "Giddiness," by Stewart, and "Albuminuria in Bright's Disease," by Jaenton.  
C. W. A.

*Atlas of Venereal and Skin Diseases.* By PRINCE A. MORROW, A. M., M. D., Professor of Venereal Diseases in the University of the City of New York, Surgeon to Charity Hospital, etc. New York: William Wood & Co., 1888.

THE eleventh fasciculus of Dr. P. A. Morrow's "Atlas of Venereal and Skin Diseases" is of special interest in regard to the text. All who know Dr. Morrow's book on drug eruptions will be well pleased to recognize the author's classical work in the form of a condensed but clear *résumé*. We might have expected, it is true, a few more plates illustrating various forms of drug eruptions, as, for instance, the pigmentation following the internal use (or abuse?) of arsenic. But we have to acknowledge, on the other hand, that the object of giving an atlas of practical value to the profession at large has not been lost sight of by the author, even when he touches a subject especially familiar and interesting to himself. The figure representing herpes zoster pectoralis makes an excellent picture of the disease, particularly in regard to color; the vesicles, some filled with clear serum and some dried up, stand out very well from the bright-red, inflamed basis. The same can not be said of Fig. 1, Plate LI (after Hebra). It has been selected, however, very wisely, we think, on account of its calling our attention to the fact that herpes zoster of the face is not so very rarely encountered upon both sides.

So much has been written about dermatitis herpetiformis (Dühring) that it does one good to see a fine picture of this rare disease in order to get an idea of what a typical case looks like. If "the pen is mightier than the sword," a clever artist's brush is sometimes even mightier than the pen. We need but compare this picture of dermatitis herpetiformis with those given by Kaposi under the head of "impetigo herpetiformis" ("Vierteljahrschrift für Dermat.," 1877, p. 273) in order to realize at a glance the close relationship of both diseases, if not identity, as some would have it. The lesions of purpura are so characteristic and easily copied from nature that we are accustomed to meet with good pictures of the disease like those on Plate LV. The relative size of the bullæ of pemphigus and their irregular distribution over the whole body is shown to advantage in the small picture of a man in sitting position (from a case of Dr. Allen). Had we not had under our own observation a few years ago a case of pemphigus foliaceus, it would be difficult for us to fully appreciate the picture representing this rare disease. The value of an atlas of skin diseases is often judged from the pictures of the more common cutaneous affections, and we are sure that the plates of psoriasis, acne, and molluscum contagiosum—contained in the twelfth fasciculus—will be widely criticised. One, for instance, will probably find in the plates of psoriasis that the scales are a little too yellowish, and another perhaps that the borders of the individual patches are a little too red and too angular in outline. Everybody, however, must concede that the pictures give a very good idea of the general character of the diseases they represent, while they

show at the same time some variations from the typical forms not infrequently met with in practice. In the description of psoriasis, proper stress is laid on differential diagnosis and treatment. In common with some foreign dermatologists, disappointment is expressed in regard to the value of antharobin, the remedy which was proclaimed to be equal if not superior to the old reliable chrysarobin. The names "acne rosacea" and "rosacea" have always given rise to some confusion. We find them here considered as distinct diseases, while the Vienna school describes rosacea under the head of, and as the first stage of, acne rosacea. By selecting Hebra's excellent picture of acne rosacea for the atlas some incongruity has established itself, it seems to us, between the illustration and the text; this chapter being headed by the words: "Rosacea—Synonym: Acne Rosacea." It must have been no small task to find the points of real interest and practical value in the surging discussions about *lichen*, and to fix them on paper by pen and brush. We are able to appreciate the clearness of style and the impartiality of opinion of the descriptive text, and we can feel the truthfulness of the pictures in regard to color and details, but we are certainly not competent to criticise more minutely this important part of Dr. Morrow's atlas.

F. J. L.

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## Selections.

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### Symmetrical Inflammation of the Skin and Simultaneous Paralysis due to some Infection.

EBSTEIN relates the history of a man fifty-five years of age affected by a peculiar inflammation of the skin and at the same time paralytic symptoms affecting the muscles of the buttocks and extremities, so as to render the use of the limbs difficult, and the fingers could not be used for anything requiring accurate co-ordination.

The dermatitis was of a bright scarlet-red color, with intense arterial hyperæmia and slight infiltration. At some points the skin was covered with small, closely packed papules. When desquamation took place the scales were thin and white, and for the most part large. The eruption spread from one part to another in a symmetrical manner. Though looking like an erythema at some parts, it had mostly the appearance of an eczema squamosum (pityriasis rubra).

The symmetrical distribution of some skin diseases is taken as an evidence of neurotic origin, and the author holds that this condition, spreading *pari passu* with the paralysis, was of nervous origin, and thinks it may have originated in a latent attack of diphtheria. He regards the exanthem and the course it ran as without any analogy in medical literature. Very transitory scarlatina-like or roseolous eruptions have occasionally been observed in even slight cases of diphtheria, but no permanent outbreak, as in this case, which lasted for several months, the patient finally dying of nephritis. According to Trousseau, urticaria is sometimes accompanied by paralytic symp-

toms which, together with anæsthesia, may persist long after the urticaria has disappeared. According to Hirsch, a skin eruption, associated with paralysis, occurs in pellagra and in acrodynia, and according to Scheube, in beri-beri.

### Syphilitic Fever.

PROFESSOR FOURNIER presented a patient at his clinic ("Journal de médecine," January, 1889) who illustrated one of the rare forms of syphilitic fever which has received the name of *typhose syphilitique*, so closely does it resemble typhoid fever.

Syphilitic fever, although so long denied, is nevertheless very frequent, especially in women. The author has observed it in no less than one third of the cases at the Lourcine Hospital.

Symptomatic fever is not very common, for most lesions appear without febrile movement. However, an eruptive fever of invasion may appear with the roseola or papular syphilide. Essential fever is much more frequent and presents two features important to know. First, it belongs to the secondary period, and especially to the first months of this period, and, secondly, it is much more common in women.

The varieties of this fever are numerous, and marked types exist, such as the intermittent, irregular, and continuous. The intermittent is one of the most common types. The initial stage is often absent as well as the sweating stage. Only simple shiverings are noted, followed by a stage of heat and a terminal stage of moisture. It ordinarily occurs at evening or in the night, and the spleen is not affected. The intermittent form passes away the most quickly, but may last as long as three months. It is the form which gives way most readily to mercurial treatment, while quinine has no influence upon it. The continued form is, perhaps, more important because of the errors of diagnosis which it is likely to cause. The temperature is usually moderate, but in some cases may reach or exceed 104°. The duration may be only a few days, but it may also last for several weeks, or even fifty days. Thus in these cases, contrary to the current opinion, syphilis may become a pyrexial disease. In syphilitic fever, digestive troubles are very slightly marked, while in simple continued fever, they are the predominant symptoms; besides, the tongue has a peculiar aspect and the fever does not last over a week. Between this and typhoid fever the diagnosis is still more important. The differential signs are mostly negative, there is absence of epistaxis, and the character of the facies is simply adynamic without stupor. There is absence of tympanitic enlargement of the abdomen, gurgling in the iliac fossa, diarrhoea, sibilant râles in the chest, enlargement of the spleen (except in rare instances), and the characteristic spots appearing on the seventh or eighth day. A peculiar phenomenon occasionally observed in syphilitic fever is that of bulimia coincident with the fever. Prognosis in the prolonged form of fever has a certain importance, for it leads to denutrition, anæmia, and a general atony from which it is difficult to relieve the patient.

As regards treatment, mercurial ointment is advised in doses of four grammes at each friction for an adult. This quantity can be increased after a few days to six or eight grammes, but this quantity must not be exceeded

unless in very grave cases or where the treatment is being carried out at a sulphur-water cure. Sulphur-water favors the tolerance of mercury without our being able to say just why. Doyon has been enabled under these circumstances to use a daily quantity of twenty grammes of the ointment without causing salivation. Vigorous friction for almost a quarter of an hour, preferably at night, is required for the smaller quantity and a longer time for the larger dose.

The region is then covered with a layer of cotton and adhesive straps and the ointment is left upon the skin eight or ten hours. Two starch baths a week are given. Professor Fournier condemns the practice of neglecting treatment in suspected syphilis in infants as long as they appear healthy. He believes that if the father alone is syphilitic, treatment is not indicated, for heredity under these circumstances is rare. If the mother has syphilis of long standing and has shown no signs during pregnancy, then, too, treatment may be omitted. If, however, the mother has recent syphilis, and especially if she has shown signs of it during her pregnancy, we must not hesitate to treat the child, even if it appears perfectly healthy. It is sure to become syphilitic, and should be treated energetically from birth.

#### **Alopecia Areata after an Operation on the Throat.**

THE contention over the parasitic or neurotic origin of alopecia areata appears to approach more and more a solution in that both theories are probably right and that we must admit two forms of the affection, so far as aetiology goes. Dr. Pontoppidan, of Copenhagen, reports a case favoring this view in the "*Monatshefte für Praktische Dermatologie*" for January 15, 1889:

A ten-year-old girl was operated upon September 7, 1888, for a glandular tumor the size of a pigeon's egg in the left carotid region. A paralysis of the sympathetic affecting the muscles of the eye on the same side, with ptosis and contracted pupil, followed on the next day, and there were chorea-like movements of the left arm. Twenty-one days after the operation, when the bandages were removed, several spots free from hair were noticed upon the neck. As these became larger the author was called in consultation. The child had had no previous skin disease or loss of hair, and no cases of alopecia were known of in the neighborhood. On the back of the head were two symmetrical rounded spots as large as a thaler quite devoid of hair. The skin was white, smooth, and free from scales, broken hairs, or other abnormal appearance. Sensibility was unaffected. Microscopic examination of the hairs showed only the usual normal microphytes in the epidermis and root-sheath. The diagnosis alopecia areata neurotica was made, and the advice given to withhold all treatment, as a spontaneous regrowth was anticipated. At first the spots rapidly enlarged, and new ones appeared on the side of the head and behind the ears and became confluent, so that by the end of a month after the first examination the whole back of the head was symmetrically hairless and smooth. The spreading then ceased and the hairs at the border were firm and strong. The alopecia occurred over the region supplied by the occipitalis major and minor, and the posterior branch of the auricularis magnus. Lanugo hairs soon appeared, stronger at the periphery



of the patch, and in about two months covered the whole region. Normal hair grew again within a few months.

This alopecia following a nerve lesion would correspond, as to the region affected and time, with Max Joseph's alopecia after lesion of cervical ganglia were it not for the circumstance of the symmetrical spread to the side opposite to that on which the operation was done. Still, Max Joseph and Mibelli have observed that the affection is not confined to the region of the extirpated ganglia, but may show itself elsewhere, as in the part supplied by the trigeminus, and also at distant points, as upon the shoulders and extremities. An extension to the corresponding nerve-tract of the opposite side, by means of a centripetally extending neuritis, is, perhaps, not impossible. Whatever the explanation may be, the case reported will have an interest as a contribution to the question of neurotic alopecia areata.

### Syphilis and Tabes.

DR. OPPENHEIM relates an instance of syphilitic affection of the central nervous system which in passing away presented the clinical picture of tabes dorsalis. The patient died of carcinoma of the uterus, and the autopsy showed pachymeningitis interna chronica, arachnitis gummosa, endarteritis and periarteritis chronica, etc. The following conclusions are given :

1. A train of symptoms very much like those of tabes can be produced by a syphilitic affection of the central nervous system.

2. If in such a case an antisiphilitic course is followed by happy results, the supposition may be held that it is not tabes, but a true syphilitic affection—a pseudo-tabes syphilitica.

3. In ordinary tabes dorsalis not only does a mercurial course do no good, but rather works injury.

4. A syphilitic disease of the central nervous system, especially of the covering membranes, can accompany changes in the nuclei of the brain nerves which are not specific in their nature, and show great similarity, if not complete identity, with the corresponding symptoms found in tabes.

The development of a nuclear paralysis due to syphilis, which has been shown by Hutchinson and others to be a possibility, is demonstrated in an almost convincing manner by the author's observation. The diagnosis of tabes must be made with reserve in atypical cases, but a long period of observation will in most instances make a positive diagnosis possible.—*Medicinisch-Chirurg. Rundschau*, Feb. 1, 1889.

### Diseases of the Skin associated with Disorders of the Female Sexual Organs.

DR. ROHÉ has brought together, in an article published in the "Buffalo Medical and Surgical Journal," February, 1889, many scattered observations which seem to show a relationship between sexual derangements and cutaneous eruptions. These eruptions are treated of under *angioneuroses*, *disorders of glands*, *inflammations*, *pigmentary hypertrophies*, *neuroses*, and *vascular dystrophies*.

Neurotic tumefactions (œdemas), erythema multiforme, erythema nodosum, and urticaria, especially the more chronic and recurrent forms, are not infre-

quent accompaniments of sexual disturbances, while acne rosacea is frequent at the menopause. Hyperidrosis, colored sweat, and blood sweat are found in company with uterine or ovarian disorder. The author ventures to term one variety of gland disorder "menstrual acne." It is rarely distinctly pustular, and appears a few days before the menstrual period. Arsenic, in doses of one one hundredth grain, has been found beneficial. Menstrual eczema and eczema of pregnancy are described, and the writer has noticed a form of acute generalized eczema which occurs in association with laceration of the cervix uteri, extends over nearly the entire surface, is finely vesicular, and accompanied by the most intense itching, fever, and subsequent exfoliation of epidermis. No treatment addressed to the cutaneous surface seems to be of any avail until the uterine lesion is remedied. Climacteric eczema occurs mostly upon the scalp and ears. Jamieson advises

R. Liq. plumbi subacetat. .... ʒ ss.;  
 Liq. carbonis detergens. .... ʒ ijss.

M. S.: One teaspoonful, mixed with a pint of warm water, to be applied with a sponge twice daily.

Eczema of the mammaræ is usually associated with lactation. That form known as Paget's disease has been shown to be epitheliomatous at a very early stage, and probably the irritation in those predisposed to cancer determines its development here. Eczema of the nipple should hence be cured as quickly as possible.

Recurrent herpes of the genitals is probably at times due to intrapelvic lesions involving the cutaneous nerve supply. Impetigo herpetiformis is almost always associated with pregnancy or the puerperal state. Furunculosis is not infrequent at the menopause, but glycosuria is common at this period, and may be detected. Localized increase of the cutaneous pigment is one of the most frequent accompaniments of female disorders. The face is usually affected, though in one case reported the left leg became black during each pregnancy. Pigmentary deposit about the eyes is not infrequent, but often feigned by hysterical women. Persistent deposits can be removed for a time at least by a drachm each of ammoniated mercury and subnitrate of bismuth to an ounce of rose ointment.

Pruritus is a very frequent condition, in some persons a regular accompaniment of the menstrual period. In cases of uterine or vaginal catarrh where acid secretions bathe the external genitals, vulvar pruritus is both frequent and intense; also at the climacteric period, when, too, it is often associated with glycosuria. Dermatalgia and hyperesthesia are mentioned as symptoms of the hysterical state, due to uterine derangement. Morphœa can often be attributed to uterine origin. Purpura is occasionally found as a rare manifestation of menstrual derangement.

#### **Increase of Scabies in Boston.**

IN an article from the pen of Dr. White ("Boston Medical and Surgical Journal," Feb. 14, 1889) a comparison is made between the past and present prevalence of scabies. During the war it became very prevalent among the soldiers, and the "army itch" was erroneously looked upon as something distinct from scabies. After this period it again almost wholly disappeared

from the neighborhood of Boston, due to the cleanly ways of family life. The number of cases treated in the skin department of the Massachusetts General Hospital was fifty in 1869. This gradually decreased to two in 1877; but since 1884, when sixty-eight cases were entered, there has been a regular yearly increase, until last year the number reached one hundred and sixty-five; and in private practice the same increase has been noted. In Professor Hardy's "quick cure" at the St. Louis Hospital the patient is rubbed all over with soft soap for half an hour; he is then kept in a hot bath for half an hour, and then rubbed with lard, three hundred parts; sulphur, fifty parts; and subcarbonate of potash, twenty-five parts. In Germany, Wilkinson's modified ointment—consisting of sulph. venal., ol. fagi, āā 3 vj : sapon. viridis, adipis, āā libram; cretæ, 3 iv—is much used.

Balsam of Peru and naphthol have both been proved to be excellent parasitocides, and Dr. White combines them with sulphur in the following proportions: Sulph. flor., 3 ij; β naphthol, 3 j; balsam of Peru, vaseline, āā 3 j, which quantity is generally sufficient for the cure of a case, a third part being rubbed in from the neck down each night and a bath taken in the morning. Subsequent itching is not a sign of the continued activity of the original affection, and the resulting eczema must not be treated as though the parasites were still present.

### On some of the Relations of Neurology to Surgery and Dermatology.

IN an address delivered before the Neurological Society of London by Jonathan Hutchinson upon his election to the presidency, which is abstracted in the "Medical Press," February 6, 1889, a variety of surgical and dermatological conditions in which the nervous system is implicated were discussed. "Dry mouth," for which the name "xerostomia" was proposed as a substitute for "aptyalism," was considered an illustration of the influence of the nervous system in controlling and entirely arresting gland secretion. Attention was directed to various conditions in which the supply of blood to different parts of the skin was injuriously influenced through the nervous system. The diseases of the skin which should be classed as neurotic might be divided into: 1. Those due directly to disease of the nerves themselves, or to some trophic influence exercised by them. 2. Those due to disturbances of the circulation produced through nerves. 3. Those in which the nervous system, although not being directly concerned, still took some share in the way of general reduction of tone. In the first and by far the most definite group, herpes and morphœa or scleroderma were the principal examples. The theory was upheld that herpes zoster was always due to peripheral neuritis. It was suggested that the one great difference between zoster and recurrent forms of herpes consisted in the severity of the neuritis in the former, which disorganized the nerve affected and thus prevented the possibility of its being again attacked. Localized scleroderma (morphœa) was very different, though perhaps not belonging to a wholly different class from that in which the affection was symmetrical, diffused, and, in greater or less degree of severity, universal. It differed from zoster in its slowness of evolution and its long persistence, and it was not at all uncommon to find it affecting several parts of the body at the same time. He believed that its earliest manifestation

was always in the form of a cluster of spots, and that the large patches often seen at a later stage were always due to a confluence of these. It was contended that hemiatrophy of the face was always the consequence of morphea affecting the fifth nerve, and occurring in early life before the parts had attained their full growth. No eruption produced directly by nerves could possibly assume a rounded form. The terms "areate" and "circumscribed" could never be applicable to disorders of nutrition located by the filaments of nerves. Under this rule it was held that such diseases as alopecia areata and leucoderma were certainly not of neurotic origin.

A second rule was that disorders originated by nerves never spread serpigginously—that is, they did not creep at their edges by infection of adjacent parts, as lupus, psoriasis, and leucoderma so conspicuously did. On account of the slowness of evolution and the difficulty of making sure of its precise limits in the early stages, scleroderma had been thought to spread at the periphery, but that such a tendency was conspicuously absent there could not be the slightest doubt. It was admitted that in many diseases not primarily affecting the nervous system a tendency to peripheral neuritis might exist which would explain the peculiar arrangement and occasional corymbiform grouping. Variola, dermatitis herpetiformis, lichen ruber, and some syphilides were mentioned in this connection. The explanation of congenital streaked eruptions, as ichthyosis occurring in lines, was discussed and regarded as difficult of explanation, as the lines often did not follow any known nerves, and it was not easily comprehensible that the transit of a nerve-trunk deeply placed under the skin should evoke any phenomena along its course.

## Items.

### Treatment of Pruritus Ani and Vulvæ.—

R Sodii hypophosphit .....	15·0;
Ac. carbolic .....	2·5;
Glycerin. pur.....	8·0;
Aquæ destillat.....	120·0.

M. S.: Use as lotion.

—*Dublin Journal of Medical Sciences*, October, 1888.

**Hyperidrosis of the Feet.**—The plantar surfaces of the feet and the interdigital spaces should be wiped from time to time with a piece of lint saturated with the following solution:

R Acid. chromic.....	1;
Aquæ .....	100.

The application can be repeated at intervals of two weeks. In case ulceration is present, one can employ in the beginning a solution of the acid in the strength of 1 to 20.—*Bul. Med.*

**Salicylate of Soda in Pruritus.**—Icard reports the case of a patient who had suffered nine months from intolerable itching of the skin, and had tried remedies innumerable, who was speedily cured by the internal administration of forty-five grains of salicylate of soda daily.—*La Gazette médicale*.

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## Original Communications.

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### THE SYPHILOMA OF THE VULVA.

By JAMES NEVINS HYDE, M. D.,

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*(Concluded from page 129.)*

THE more carefully the literature of this theme is explored, the more surprising appears the fact that a group of authors, numerically so insignificant, writing for the most part since the middle of the present century, have been able to hold this exceedingly precarious position with such an appearance of success. They have, in fact, decided that disease to be lupus vulgaris, none of whose symptoms are enumerated under the title of lupus by any dermatological writer of repute, and most of whose symptoms point conclusively to quite another disease. Lupus vulgaris is a malady one half of whose victims first display its symptoms before the tenth year of life, while the so-called esthiomenus of the vulva is, almost without exception, a disorder of the third decade, in women who have sustained relations with the other sex—a class distinguished above all others for the display of syphilitic symptoms. Further, as compared with syphilis, lupus vulgaris is a disorder of great rarity, the chances of any single case belonging to either category being more than one hundred to one in favor of syphilis; yet Matthews Duncan asserts that, in the wards where his statistics were gathered, they were “seldom without” cases of esthiomenus of the vulva. On the other hand, Mr. Jonathan Hutchinson, who was early in pointing out that some of Duncan’s portraits suspiciously resembled those of syphilis, and who reiterated in his Harveian lectures on lupus the fact that the genital organs are almost wholly exempt from the disease, neglects to describe a syphiloma of the vulva in his lately published treatise on syphilis. Hebra, Sachs, Anderson, Fox, Neumann, the several members of the American Dermatological Association, and others,

have collected statistics of about three thousand cases of lupus vulgaris without describing an instance where the vulva was primarily involved.

Again, the primary lesion of lupus vulgaris is recognized by most dermatologists as a minute nodule scarcely larger at first than the head of a small pin, and rarely increasing beyond the dimensions of a split pea. The writer has now under observation a patient affected with lupus vulgaris of the right cheek, originally operated upon by the late Dr. F. J. Bumstead, in the year 1840, and in this patch there are lesions persisting to-day not exceeding in size four millimetres in diameter. But the lupous nodules of some of our gynæcological authors are many of them as large as pigeons' eggs; and one of these gentlemen furnishes an illustration of lupous tubercles of the vulva which, even in the colored prints, measures two inches in longest diameter! Further, lupus vulgaris, as contrasted with syphilis, is a malady exceedingly chronic in course and slow of evolution, yet another author in this field describes a case of esthiomenus of the vulva and anus completing its entire stadium and destroying its victim in the relatively brief period of twenty months!

But a still more extraordinary feature of these records is the express admission on the part of both authors and patients, catalogued in the lists of esthiomenus of the vulva, that some of the latter had been actually infected with syphilis. Many indeed of these records are, as stated above, those of public women treated in the hospitals of Paris. The usual extreme of the ignorant, in ascribing every accident to syphilis if there be only a history of chancre, seems here to be shifted to the opposite pole of error with astounding fatuity! With an unmistakable history of primary syphilis, of syphilodermata, and even of disappearance of symptoms under syphilitic treatment, the obvious inference has been ignored and the cases described instead as those of a disease most common in infants and children, and those who have never sustained relations with the opposite sex. They assign, expressly or by inference, one of two reasons for this course: First, it is assumed that, though previously syphilitic, these patients have recovered from that disease because there are no symptoms of its existence [and the esthiomenus is not held to be such a symptom]; or, second, that the esthiomenus symptoms are a compound of syphilis and something else—a *tertium quid*—a composite of lupus and syphilis, resembling neither, and yet partly both. Such a position is the common resort of weakness or ignorance. Few, indeed, whose names are associated with this question have adopted it. Landau, however, is of this number, reporting five cases of so-called ulcus rodens of the genitalia of women, four of whom were unquestionably syphilitic. He admits that syphilis was the basis, but adds that an ulcerative process of unknown nature was developed later; yet, in all, there is a distinct history of gummatous involvement of the urethral walls with peri-urethral infiltrations and nodules encircling the urinary meatus.

The doctrines thus advanced about hybridism in disease are generally regarded with a just suspicion. If nature "abhors a vacuum," it is none the less true that every morbid process contests its ground with every other that differs from it. Even "the itch" temporarily abandons its victim when an exanthematous fever is in progress. The author has studied syphilis in coexistence with psoriasis, eczema, typhoid fever, pulmonary phthisis, and a number of surgical accidents, as well as idiopathic disorders, and his conclusions are in accord with the experience of others in the same field. When the one disease is in a period of activity, the other is, almost without exception, in abeyance. Nor are the symptoms of these cases by any means generally of a mixed or hybrid character. A psoriatic patient now under observation has a characteristic patch of syphilitic tubercles on one buttock. A syphilitic patient, two months ago, passed through a classical stadium of typhoid fever, without syphilitic symptoms, which nevertheless did not fail to appear in typical form as soon as convalescence from fever was established. As if even the exception proved the rule, the author has published an account of a patient who had lupus in childhood, the diagnosis having been established by Hebra himself; subsequently, when an adult, this same patient contracted syphilis, whose phenomena were quite unmodified by the earlier disease.

Lastly, the fact that lupus is a malady of childhood and has in marked cases wrought its mischief before the puberal epoch, has probably operated indirectly to insure the statistical preponderance of the unmarried among its female victims. As before shown, the majority of patients displaying the lesions of so-called esthiomenus of the vulva are women who have sustained relations with the other sex. The few virgins reported as suffering from esthiomenus of the vulva have presumably suffered neither from syphilis nor from lupus, but from some other distinct affection, as will be clear to one who carefully studies these exceptional cases. Two or three cases, however, of this disease appearing first in childhood may be set down as the remarkable exceptions to this rule.

In what has preceded it is by no means intended to advance the preposterous claim that all the cases of so-called esthiomenus of the vulva are syphilitic in character. No position could be more untenable. That some, however, of the cases thus recorded belong to the category of syphilis there can be no reasonable doubt. It would be going too far to decide as to the latter what proportion are and are not syphilitic. Nor would it be pertinent to the subject in hand to decide, from the study merely of published details, what other diseases besides syphilis have been unfortunately included in the esthiomenus lists. The suspicion is aroused that some of these are cases of labial epithelioma, some of rapidly fatal sarcoma, others of benign vegetations of the sort described by authors as papilloma, fibroma, and the grave complications, phlegmonous and ulcera-

tive in type, of the severe lacerations of the external generative organs of women resulting from the accidents of childbirth.

Even a very few cases, carefully observed, in which all the classical phenomena of earlier syphilis have resulted in symptoms of so-called esthiomennus of the vulva, without intercurrent accident or complication, ought to suffice to clearly establish this as one of the possible consequences of that disease. Such cases are recorded. Jullien hesitates to accept the fact, but the grounds are not stated for this hesitation. One of the cases observed by the author fulfills the needed requirements. A woman with dense hypertrophy of the labia, horse-shoe-shaped vestibular ulceration, gummatous thickening of the entire ostium vaginae, and characteristic ano-perineal languettes, or tags, whose case had been pronounced one of esthiomennus of the vulva by a physician of national reputation and undoubted skill, gave an unequivocal history of post-marital infection, and was relieved by specific treatment.

If lupus vulgaris is a rare affection of the genital region, with still greater emphasis may this rarity be affirmed of a disease with which for some time the attempt has been made to identify lupus—viz., tuberculosis of the skin. From such exceedingly rare forms of tuberculosis there can be even less difficulty in distinguishing vulvar syphilomata than from lupus. Tuberculosis of the vulva is indeed a pathological curiosity. Zweifel, after an exhaustive search of literature, reports that he was unable to discover a single well-authenticated case. Chiari, however, since this attempt, reports a case observed with all scientific requirements, and, as it almost stands alone in its special category, it is particularly interesting. A woman, thirty years old, had generalized tuberculosis involving the lungs, brain, liver, and other viscera, as well as the external genitalia. In this region, however, there were no dense labial gummata, as in the cases to which we have called attention above, but, instead, oedema of the vulva, and ulceration of the labium majus of one side, with firm borders and clean-cut, indented edges, the base of which was thickly overspread with cheesy nodules. More significant still, numerous ulcers of a similar character studded the upper as well as the lower vagina, the anus, and the rectum. There were abscesses of the swollen inguinal glands with a fistulous tract in one leading down to a cheesy focus of central situation. Numerous bacilli of tuberculosis, both intracellular and inter-cellular in site, were recognized before and after death in properly stained tissues. Even macroscopically, says the author, the diagnosis of tuberculosis might be established by discovery of the numerous cheesy nodules scattered over both ulcerated and non-ulcerated surfaces.

True elephantiasis of the vulva is another exceedingly rare affection to be differentiated from syphiloma of the same part. In well-established cases of the malady first named the enlargement is commonly far greater



than that displayed in syphilis. The labia or clitoris form pendulous tumors of gigantic size reaching to and even below the knee—dimensions never attained by the syphiloma. They are often preceded by attacks of lymphangitis or erysipelatoid inflammation with resulting œdema and coincident pyrexie symptoms. Recurrent accesses, each followed by marked increase in the dimensions of the voluminous labia or clitoris, are valuable in diagnostic import. Rarely does any accompanying ulceration reach out the urethra, or produce contracture of the vaginal orifice. Almost never can one observe in elephantiasis of the labia the moderate-sized, dense violaceous, knobbed or uniform enlargement seen in the syphiloma of the same organ on one side, producing in totality a tumor resembling in situation and size a vertically attached sausage. Ulceration, furthermore, of the small gummatous nodules of the syphiloma is of earlier occurrence than that following elephantiasis of the vulva.

Many cases, however, reported as “elephantiasis” of the vulva are actually syphilitic. One such is found in the author’s list. The patient was a Frenchwoman admitted to one of the Chicago hospitals with a dense fist-sized tumor of the right labium majus, existing for three years, made up of agglomerated nodules. The case had been set down as “elephantiasis” by the cautious surgeon who asked my opinion in the case. A subsequent rigid sifting of her statements disclosed a history of syphilitic infection, of syphilodermata and tibial ulcers, whose previous existence was confirmed by the discovery of two typical scars on the legs. Of Rosenkranz’s two patients reported as elephantiasic, one seems to have been syphilitic; the other had suspicious scars on the neck. The cases of pseudo-elephantiasis of Berkeley Hill, and that of elephantiasis reported by Boyd, furnished egg-sized masses, labial in situation and occluding the vagina, lobulated, fissured, ulcerating, and exhibiting features strongly suggesting vulvar syphilomata.

Primary epithelioma of the vulva is a rarer affection than the syphiloma of the same part. In one case under the author’s observation, from the beginning a perfectly typical group of so-called cancer “perles” involved the skin of the mons Veneris in a fleshy married woman, fifty years old, who was passing through the period of the menopause. The patch did not for two years exceed in dimensions a fifty-cent piece. These slowly formed a shallow, red-floored, scantily secreting excavation, seated on a firm and attached base. After excision, characteristic “nests” of epithelium were seen in sections examined under the microscope. At no time could this lesion have been in any way confused with the firm, deep-seated, subcutaneous nodules of a syphiloma situated upon or between the labia and more rapid of evolution, chronic though their course be, than the indolent epithelioma. Similar microscopical proof of the character of one of these rare growths was lately obtained in the case of an epithelioma excised from

the clitoris by Richet, in the Hôtel Dieu de Paris. The patient was a healthy-looking woman, forty years old, and the reddish tumor of the clitoris had been developing for six months. There was a characteristic cauliflower-like arrangement of its lobes. In these cases the age of the patient, the point of origin of the local disorder, its external characteristics, and the entire absence of multiple lesions, including vestibular ulceration and ano-perineal tags, are useful in establishing the diagnosis clinically.

Primary sarcoma of the vulva, still rarer than any of the lesions named above, may be said not to figure in the literature of medicine. In the single case to which reference was made above it seemed probable that the disease began by involvement of the os tincae. Of the other tumors to be recognized in the vulva, few are likely to be confused with syphilomata. Labial cysts, due to distention of the vaginal process of the peritonæum about the broader ligament, lipoma, lymphangioma, labial thrombus, hernia, blennorrhagic involvement of the vulvo-vaginal gland, and an unusually large initial sclerosis of syphilis with inguinal buboes, could scarcely be confounded with the long-lived, indolent, painless, solid and dense neoplasms, without glandular complications, which have here been passed in review.

Mann, under the title "diffuse fibroma" of the vulva, presents two illustrations of the disease, which, as above suggested, certainly present the features of syphilitic lesions. The author apparently recognized the futility of further reporting such cases under the title of esthiomenus of the vulva and anus. A part at least of the ground which it has been the effort of this paper to cover seems to have been open to him. A well-meant effort to evade these consequences seems to have led him to this singular position. But neither in histological features, history, clinical symptoms, or complications do these lesions conform in the least to what has been established in cases of fibroma. It is none the less clear that this late and yet first effort of any writer on diseases of women to escape from the incongruities of the doctrines respecting esthiomenus of the vulva, held by so many of that school, is entitled to high credit.

*Pathology.*—The relations of syphilis to the group of disorders now recognized as infectious granulomata, due to the presence in the body of noxious micro-organisms, are not yet definitely established. Certain it is that pathologists have thus far failed to identify, by histological characters, the lesions described above as syphilitic in nature. This is only what might have been expected on *a priori* grounds. There are few living pathologists who would hesitate to pronounce positively on the nature of a tumor whose sections exhibited typical features of an epithelioma or spindle-celled sarcoma. Yet scarcely one of them would be willing to risk his reputation on an opinion based upon microscopical examination of a section of chancre.

Vulpian, Robin, Cornil, Weber, Wedl, Paget, Arnold, and others besides the author, have examined sections of tissue removed from cases of so-called esthiomenus of the vulva; and the results may be set down as altogether unsatisfactory so far as concerns any identification of a special disease. Small, roundish, elliptical or polygonal, nucleated and non-nucleated cells, with and without prolongations; engorgement and infiltration of all tissues involved, periglandular and perivascular, including the lymphatic and blood-vessels themselves, some with obliteration of the lumen, some dilated—these are the phenomena chiefly observed under the objectives. Most pathologists are limited to this admission: that the evidences are not incompatible with the existence of syphilis. Few of them all have set themselves to the task with any clinical evidence furnished them as to a syphilitic origin of the disease to be studied. And yet it is only as the handmaid of clinical medicine that pathology has garnered its best fruits. The near future promises to clear much of this obscurity by the demonstration in these cases of a micro-organism which can be identified as like and yet unlike those efficient in the production of the other infectious granulomata. For the present we must be content to recognize a gumma of the vulva as we do a gumma of the breast or the brain—by the general characteristics of these lesions and the special modifications to which they are subject in particular regions of the body.

*Treatment.*—The treatment of these apparently intractable cases is far more simple than at first appears. Many patients are not cachectic, and improve under the use of mercurial and iodine compounds, precisely as in cases of gummatous changes of testis or periosteum. The fewer victims of cachexia improve under the usual roborant regimen, including the use of the ferruginous tonics and mineral acids, good food, and a properly regulated hygiene. Excision and destructive cauterization of flaps, tumors, and tags are often required; and, usually proving effective, are not followed by a return. But no remedial measures are at all comparable with daily skillful local dressing of the affected parts. Very few women who are victims of the disease in any advanced stage are capable of properly making these dressings themselves. A skilled assistant is needed for the most. Ulcerations are to be daily cleansed and wiped thoroughly with solutions of the nitrate of silver in varying strength, and then dusted with iodoform, iodol, or, what is decidedly preferable for the majority, one part of hydro-naphthol to fifty or one hundred of fuller's earth. When there is vestibular ulceration, the urine should be passed in a vessel containing water, to relieve the dysuria. When there is painful defecation, on account of ano-rectal complications, the anus should be anointed before each stool with a salve containing one drachm (four grm.) of the tincture of benzoin to the ounce (thirty-two grm.) of salve-basis, or some preparation of this kind. In severe cases the recumbent position is to be maintained for weeks.

One of the author's patients illustrated well the need of persistent and faithful dressing of the affected parts. The woman had visited the Hot Springs of Arkansas without result, save to secure an opinion that she was suffering from lupus of the vulva. On reaching home she was placed in a hospital and subjected to treatment with proper dressings by a skilled nurse. As soon as even a moderate improvement was realized she insisted on returning to her husband, with whom sexual relations were, as usual in such cases, promptly re-established. She thus speedily relapsed into nearly her former condition, when her husband committed a crime against the State which led him to become a fugitive from justice. Abandoned thus, the woman was finally placed in the care of an attendant who skillfully dressed the parts every day for two months. At the end of that time the change was marvelous, the patient being practically restored to health.

*Prognosis.*—For the most of patients, more particularly those who have not been lacerated in childbirth and have not become cachectic, the prognosis is exceedingly favorable. Fatal results, even in the worst cases, need not be anticipated with the resources of modern science. When there is ulceration of the urethra and vestibule, the relics of this process are last to disappear, the urine invariably aggravating the local disease in its passage over the meatus.

The table subjoined exhibits the main features displayed in the cases observed by the author, and to this is appended a bibliography.

Date.	Name.	Age.	Condition as regards marriage.	History.	Symptoms at date of examination.	Extra-genital signs of syphilis.	Public or private practice.
1872	J. E.	35	Single.	Several years of prostitution. One or two miscarriages. Infection reported at twenty-fifth year. Present lesions have existed four years. Complaints of itching.	Left labium majus violet-hued, fist-sized, dense, and knobbed. Vestibular ulceration. No inguinal adenopathy. General appearance excellent.	None.	Hospital.
1874	E. T.	26	Md.	Frenchwoman; twice married. Charges infection on first husband. One abortion at fourth month; one puny child died in second year; both by first husband. Married four years to second. Reputed to have "elephantiasis of vulva" for three years.	Right labium majus converted into sausage-shaped tumor. Clitoris knobbed and enlarged. Both organs of stony hardness. The ostium vaginae infiltrated and converted into an inextensible ring; its inner face eroded. Individual marble-sized masses distinguished in labium. No inguinal disorder.	Two circular, delicate, partly pigmented scars on anterior in-surfaces of left leg (tibial region).	Hospital.
1880	M. N.	28	Md.	Jewess; six years married. No pregnancy. No history of infection. Present condition gradually progressing for three years and a half.	Dark-skinned, fleshy woman, with gummatous nodules of vestibule and large gummatous ulcer of labium majus, about which are set four marble-sized masses of great firmness. Perineum indurated.	Typical patch of cicatrices of tuberculo-ulcerative gummata, right buttock.	Private.
1882	A. P.	38	Md.	Married ten years. Three healthy children, followed by two miscarriages. Local	Both labia majora densely infiltrated, the right larger than its fellow. "Y-shaped" ulcer of four-	None.	Public.

Date.	Name.	Age.	Condition as regards marriage.	History.	Symptoms at date of examination.	Extra-genital signs of syphilis.	Public or private practice.
1884	E. Q. S.	40	Md.	disease for three years. History of marital infection, syphiloderma, and mucous patches.	chette, with mammillated surface and irregular borders. "Languettes" and perineal ridge. Anus beset with fleshy masses and retracted. General health poor. Some cachexia. No enlargement of inguinal glands.		
1884	E. Q. S.	40	Md.	Married at twentieth year. One healthy living child, at birth of which she was "torn." Two miscarriages since, each at seventh month. Distinct history of infection by husband after delivery, with subsequent cutaneous and mucous symptoms.	Gigantic ash-colored ulceration involving anus, vulva, perinaeum, and urethra, the whole converted into a wide chasm crossed by bundles of tissue, and covered in part above by the pendulous urethra. The labia stuffed with marble-sized masses and projected from the general plane. No inguinal adenopathy. Grave cachexia.	None.	Private examination of old dispensary case.
1888	M. N.	20	Md.	Admits pre-nuptial infection by a lover. Married four years. Local disease for "about three years."	Typical vestibular ulceration, with pea-sized nodules and oedematous clitoris. The ulcer is horse-shoe shaped, and its free ends are upward. The meatus urinarius is characteristically "reamed." No cachexia. Moderate pallor. No inguinal change.	.....	Private.
1887	R. D.	28	Md.	Married a second time, and infected by first husband after one year of marriage. History of syphiloderma, alopecia, and mucous patches. Case treated in Hot Springs of Arkansas for esthiomenus of vulvo-anal region. Local disease for "four or five years." No pregnancies.	Excellent general health. Labia majora and minora, ostium vaginae, perinaeum, and external anal folds infiltrated and indurated. Right labium dense. Marble-sized nodules in nymphæ of same side. Coarctation of ostium vaginae. "Languettes" spread over vagina, perinaeum, and anus. Horse-shoe shaped vestibular ulcer. No inguinal adenopathy. Dysuria. Painful and bloody defecation. Coitus painful.	None.	Private.
1887	M. K.	23	Md.	Married for three years. One healthy child in first year. Vulvar ulceration for two years and a half. One miscarriage since.	Mammillated horse-shoe shaped ulcer of vestibule. Induration and infiltration of right labium majus and nymphæ. Clitoris dense and tumefied. Violaceous thickening of ring constituting ostium vaginae. No inguinal adenopathy. General health fair. Dysuria. Coitus painful.	None.	Private.

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## THE INFLUENCE OF OCCUPATION IN SKIN DISEASES.

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**O**CCUPATION has its bearing in all disease. Every physician, it is needless to say, is cognizant of this fact. And as with an inquiring eye he scans the patient, it may be in a case of aneurism, or it may be in a case of lead paralysis, yet, whatever the ailment, the thought crops up, as having considerable weight and being a possible cause, as instinctively he puts the much-asked question, "What is your occupation?" And the frequent reply, "Laborer, sir," as he unravels the meaning of that comprehensive term, and finds out that the man has been in the habit of lifting heavy weights, or has been a bricklayer, or plasterer, often assists in more strongly confirming or clearing up his diagnosis. The labor question, aside from its obstetrical aspect, invades the mind of the physician as well as the politician. It is a question as pertinent to the

dermatologist as to the general practitioner, and frequently aids in solving many dermapathies. With a view of brushing away some of the cobwebs that may perchance hover around the memory of the profession on this subject, the following is respectfully submitted :

The proletariat are the chief sufferers. The occupations, multifarious. When Registrar-General, the late Dr. William Farr, of London, divided the occupations in England into six grand divisions, which apply with equal force in this country.

Class I. *Professional* (men and women), subdivided into three orders : (1) *Governing order* : consisting of those in the direct employment of legislature for governmental purposes, civil servants, etc. (2) *Defense order* : soldiers, sailors, policemen, etc. (3) *Learned order* : lawyers, physicians, clergymen, as well as those engaged in the fine arts, actors, teachers, chemists and druggists, etc.—Class II. *Domestic* (men and women) : housemaids, cooks, butlers, etc.—Class III. *Commercial* (men and women).—Class IV. *Agricultural* (men and women).—Class V. *Industrial* (men and women). Six subclasses : (1) Those engaged in mechanical and artistic productions : printers, bookbinders, toy-makers, etc. (2) Workers in textile fabrics and articles of clothing : flax, cotton, silk-workers, dressmakers, and tailors. (4) Those dealing in animal substances : butchers, poulterers, fishmongers, etc. (5) In vegetable : millers, bakers, fruiterers. (6) Those who obtain and prepare for use the mineral wealth of the country : miners, silversmiths, etc.—Class VI. *Indefinite and non-productive persons*. Three subdivisions : (1) General laborers of indefinite occupation who perform odd services. (2) Those of position and property without occupation. (3) Scholars and children not engaged in any profitable productive occupation. Subdivision (1) includes those less honorably employed : vagrants, gypsies, criminals, and disreputable women.

The above divisions of labor serve as fitting texts for the many ills they give rise to. All have more or less an influence on, or are productive of, skin diseases. In the first class, the governing order, there is a tendency to constipation and dyspepsia, and, as a consequence, acne, eczema, etc., from their sedentary mode of life. Exposure to wind and weather causes thickening of the corium (Krause) ; we have, therefore, a red face with thickened skin, and frequently erythematous eczema, or acne rosacea, in those exposed to climatic influences, as soldiers, policemen, sailors (the defense order). Coachmen and cabmen suffer in like manner. Sailors and soldiers are liable to scurvy. Stablemen run the risk of equinia and tinea trichophytina. The learned order suffer from acne, eczema, and other skin affections produced by a sedentary life. Actors and actresses, from their excessive use of cosmetics, may have acne. Druggists and chemists, dermatitis of various shades. Class II suffer from acne ; scrubbers, callus, usually below the knee ; washerwomen, eczema of the hands.

Those who handle the broom, callus. Domestics and laundrymaids, from diminished secretion of the sebaceous glands (asteatosis). Soap-boilers suffer likewise. Class III: Commercial travelers run the risk of catching tinea sycosis, scabies, and pediculi, from their nomadic habits. Business men suffer from alopecia. Those with much mental strain, from eczema, as also those of irregular habits. The agricultural class are liable to erythema calorica, chloasma calorica, rhus poisoning, and the bites of the harvest mite. Gardeners and florists are liable to dermatitis venenata. The industrial, the largest, are prone to many eruptions. Toy-makers are liable to arsenical eruptions; gilders, to eczema, alopecia, from absorption of mercury; flax-workers, to acne, dermatitis, etc.; silk-weavers, dermatitis, etc.; jute-workers, eczema; tailors and dressmakers, acne, from their sedentary position. Tailors also suffer from scabies and eczema; the heat of the iron and moisture of the cloth are predisposing causes. Jamieson \* relates the case of a tailor who every time he handled certain homespun cloths suffered from an eczema. Butchers, wool-sorters, etc., suffer from ecthyma and anthrax. Dissectors, those making many post-mortems or handling dead animals, butchers, etc., are prone to anatomical tubercle. Millers, bakers, etc., to eczema, dermatitis, etc. The wool of Texan sheep may cause a dermatitis. Dog and pet animal fanciers may contract tinea trichophytina. Miners working in copper mines may have their hair turn green; those in cobalt, blue; in coal, black. The workers in lead and copper mines may suffer from acne. Prostitutes are prolific disseminators of syphilis, etc. Vagrants are prone to pediculosis (vagabond's disease); prisoners, to scabies, pediculi, etc. Cooks, bakers, typesetters, car-drivers, tanners, etc., those whose occupation necessitates much standing, are liable to venous hyperæmia of the lower extremities. Veins become enlarged and twisted into cords (varicose veins); an eczema usually accompanies this condition. Those of sedentary habits—clerks, literary men, etc.—have a like telangiectasia of the pelvic organs (hæmorrhoids). Literary people are prone to alopecia, due, perhaps, to the higher development of the nervous system. In the second subdivision of the last class we have persons of position and money without occupation. They are essentially sedentary; usually high livers, even to cloying (though often their livers are below par), and, like the country, burdened with a surplus, which, however, is not the gold coinage of vegete, exuberant health, but rather the copper *verdigrised* with debility and *ennui*; who, following in the wake of the politician, instead of by some active occupation or exercise stimulating their digestive organs into functional activity, increasing their secretions, quickening the action of stomach, liver, spleen, and kidney, and getting rid of their superfluity, or turning their ingesta into firm muscle and vital

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\* "Treatise on Skin Diseases," 1888.



force, allow it to lie dormant within the treasury of the body, producing no dividend, generating ptomaines and leucomaines, and becoming a *materia peccans*, redolent of disease; and by reflex action, together with a sluggish circulation of the skin capillaries, setting up cutaneous eruptions, thus making themselves fit subjects for an eczema, acne, etc. Occupation acts as a direct irritant to the skin or indirectly through constitutional disturbances.

Workers may suffer from the effects of (1) dusts, (2) soluble substances, (3) gases or vapors.

*Dusts.*—Belong chiefly to the industrial class. The numerous dusts may block up the sebaceous glands and lead to an acne, or, in a delicate skin or one predisposed to cutaneous affections, set up an eczema or tend to keep up and irritate an existing one. Those incommoded are the *potters* (fine earthy or silicious dust with exposure to lead), *millstone and quarry cutters* (fine particles of stone), *sand-paper makers* (minute portions of glass and sand), *pearl-cutters* (pearl dust), *knife and needle grinders* (fine particles of steel), *hemp and flax dressers* (dust from hemp and flax). Prof. Leloir,\* of Lille, describes an affection of the skin occurring among flax-spinners. It affects the hands, especially the left one, generally symmetrical, the internal surface of the thumb principally, the external and palmar surfaces of the index finger, and cubital and palmar border of hand and little finger. In severe cases it extends over the whole hand, rarely up the forearm to elbow.

*Symptom-complex.*—Inflammation of an eczematous type, sometimes erythematous-vesicular, sometimes vesico-pustular or squamous. Most often of a dry lichenoid character. Skin thickened and its folds pronounced. Epidermis glossy, sometimes scaly, nearly always fissured. Horny layer of thumb and fingers thickened. Nails rarely affected. Pruritus variable. Workmen sometimes only affected when working; in others, dermatitis lasts weeks after ceasing work; in rare cases affects soles of workmen who go with naked feet. Peculiar to spinners who work flax in a moist state. Workers in flax may suffer from acne cognate to "tar acne." Purdon † reports such cases, principally among young girls. Dr. White ‡ considers it "not proven" that the inflammation is due to the flax itself, and cites several letters from proprietors of large flax mills in proof of its innocent character. Workmen § in jute mills complain of cutaneous eruptions, prominent among which is eczema of the hands and feet. *Workers in rags and wool* are prone to ecthyma and anthrax. *Millers and flour-workers, bricklayers, plasterers, wood and ivory turners,*

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\* "Annales de dermat. et syph.," 1885, p. 129.

† "Treatise on Cutaneous Med."

‡ "Dermatitis Venenata."

§ "Berlin. klin. Wochenschrift," 1881, p. 503.

*miners, hair-dressers, fur-dyers, trimmers, rope-makers*, may suffer from cutaneous eruptions caused by the dusts peculiar to their respective occupations. Workmen who have much to do with coal—miners, firemen, etc.—often have small particles of carbon planted in the skin which look bluish-black like powder burns.

*Soluble Compounds.*—*Artificial flower makers and paper-colorers* (arsenic). Workmen employed in manufacturing and manipulating preparations of arsenic used largely in the arts—as wall-paper, artificial flowers, printed and dyed cloths, curing hides and birds, etc.—often complain of cutaneous eruptions.\* The lesions for the most part are in the mildest form. Erythema, which is diffuse, later small papules, increasing in size, or fine transparent vesicles and pustules may arise. The last are conical, with red base, rapidly becoming purulent at their tips and covered with yellow crusts. The pustules may be converted into ulcers, round, with grayish or reddish moist base, sometimes surrounded by a dense induration. It is liable to penetrate the cutaneous lesion deeply and cause pain. Most frequent seat of the eruptions, the hands, especially about the nails and forearms. May affect face, especially lips and nose, behind the ear and about the neck, scrotum, thighs, and toes. Allen reports cases of arsenical dermatitis in longshoremen engaged in unloading a cargo of dry hides cured with arsenic. *Cigar-makers* (absorption of nicotine and tobacco dust). *Workers in mercury and looking-glass manufactories* (mercury). Mercurial eruption begins as red papules, vesicles, or small pustules, which multiply to a large extent and close to one another. *Workers in lead* (lead): painters, plumbers, and glazers of pottery, etc. Painters frequently suffer from acne from putting their hands to their face and blocking up the sebaceous glands with lead. *Bichromate workers* (bichromate of potash). Dyers using the bichromate of potash suffer from a malady called the “chromate disease.” It consists of a papular and pustular eruption of the hands, forearms, and exposed parts of the body. Deep ulcers and sloughs frequently occur, with ulceration of the mucous surfaces and perforations of the septum nasi. *Workers in paraffine* (paraffine or shale). Workers in crude paraffine, brought in contact with the shale and oily matter mixed with it, suffer from cutaneous affections (Piffard, Ogsten). Backs of hands most severely affected. Palms and soles unaffected. Redness and induration confined to the hair follicles. After a time the follicle is left enlarged with mouth dilated and patent. Black dots on skin strikingly marked, more especially in those with coarse, dark skin. A peculiar honeycombed appearance of derma, which is elevated, thickened, and inelastic, so as to render flexion painful and difficult, is observed on the back of the hands, feet, fingers, and toes in chronic cases; due to densely grouped clusters of hair follicles, distended

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\* “Drug Eruptions,” by Morrow.

with epithelial cells. Hairs become atrophied and disappear. Cracks and bleeding fissures form. Workmen are sometimes obliged to give up their occupation.

*Noxious Gases and Vapors.*—These may set up a dermatitis or eczema, or excite one already present. The sufferers are: *Lace-frame workers* (fumes of coke stove, carbonic-acid gas, carbonic oxide), *straw-bleachers* (sulphurous-acid fumes), *hat-makers* (vapor of ammonia), *workers in aniline dyes* (aniline vapor), *toy-balloon makers* (vapor of bisulphide of carbon), *photographers* (vapor of the cyanides). Hands sometimes affected with eczema by being in contact with the cyanides. The hot fumes of tobacco smoke may irritate an eczema. In those predisposed, the irritation of a pipe may awake an epithelioma (smoker's cancer). The pipe serves as a carrier of syphilitic contagium. *Alkali manufacturers*: Those employed in making sulphuric acid, washing-soda, hydrochloric acid, chloride of lime, etc., suffer from the vapor of sulphuric acid, hydrochloric acid, and chlorine gas. *Fur-dyers* (fumes of nitric acid). Printers who clean their type with alkalies may suffer from a dermatitis. *Chemical manufacturers* (gases before mentioned, also irritating dusts). *Chrysarobin*: Workmen employed in cutting up and powdering the wood of which the powder is made are compelled to protect their hands, eyes, and throat from the irritating dust (Morrow). Those making quinine suffer from skin eruptions which sometimes oblige them to give up their occupation (Chevallier, Bergeron, Prost). Those who boil the bark, convert into a sulphate, and place it in bottles, most affected. Affects hands, forearms, face, and genitals; rarely the whole body. Accompanied with great itching. Consists of erythema, vesicles, pustules, and crusts. Lasts from a fortnight to a month. Produced by emanations from quinine. Some workmen unaffected; others get inured to it—a state of *accoutumance*. Simple residence in factory, without employment, may cause it. *Monk's-hood*: Working the plant for aconitia often produces a severe dermatitis (Lloyd). Plants containing *anemone* may cause redness, vesicles, and ulcers (Lloyd). Rue may also set up a dermatitis. *Vanilla* gives rise to itching of hands and face, with dermatitis. *Podophyllum* likewise. Those employed in fabricating the oil of bitter orange suffer from inflammation of the skin. The oil contains a hydrocarbol called hesperidene. M. Imbert Gourbeyre likens it to that of camphor. Efflorescence very persistent. Bazin describes cases occurring in workmen peeling the orange in France. *Ustilago hypodites*: Gerbeau \* describes an affection occurring among the workers in reeds in Provence due to this fungus. Affects face and genitals. Sets up a severe dermatitis resembling erysipelas. *Match-makers* (phosphorus fumes). *Brush-makers* (resinous fumes from resin used to fix the bristles). *Copper-smelters* (fumes of copper ore; contains sulphuric

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\* "Annales de derm. et de syph.," Nov., 1885.

acid, traces of arsenic, free carbon). Workers in brass are subject to acne. *Painters* (turpentine vapor). Painters may suffer from eczema produced by the vapor or spirits of turpentine mixed with the paints. Artists and amateur dabblers in art suffer in like manner.

*Mechanical Influences.*—Carpenters and joiners are prone to callus. The occupation of patient may be diagnosticated from the site of callus. Dr. Lesser,\* of Leipsic, has seen it develop on the backs of the fingers in physicians who practice immediate percussio. Violin, harp, and guitar players are frequently affected with it. Those who have much manual labor may suffer from verruca. Exhausting labor may awake a slumbering tendency to psoriasis. Pressure of heavy weights, as in carriers of heavy weights, may set up an eczema. Pressure of tools of handicrafts may give rise to a pigmentation of the skin (chloasma traumaticum), or eczema. According to Hutchison, the irritation of tools of employment, or a walking-stick, umbrella, etc., may in a syphilitic subject set up a skin lesion of the hand. Also pressure on the ischium in those whose occupation is sedentary. A hyperplasia or aplasia of the nail (possibly an onychogryphosis) may be set up by the use of tools, alkalies, or dilute acids in various trades (joiners, hatters, etc.). White spots are sometimes seen on the nails of artisans and hard-working day-laborers. Professor Geber attributes them to insufficient cornification of the nail cells due to mechanical influences. Certain tools used in manufacture, as the pipes of glass-blowers, may give rise to syphilis. In France a law has been passed that each workman must have his own mouthpiece (Bumstead). Friction increases the scarf scales by stimulating the cells to greater action. Hence the horny matter on the hands of cricket, tennis, and base-ball players, oarsmen, etc. The workman's hands eloquently bespeak labor.

*Miscellaneous Influences.*—Drivers in winter-time may complain of dermatitis congelationis. I had the pleasure of seeing an interesting case in Dr. Wigglesworth's clinic at the City Hospital. Hands affected. Dr. Potton, of Lyons,† says silk-weavers who unwind the silk from the cocoons suffer from a dermatitis of a mild and severe type, affecting the hands. He attributes it to the presence of a worm in the cocoon, its decomposition and changes which take place in its interior.‡ When the atmosphere of working-rooms is impregnated with tarry vapors, or workmen are employed over machinery lubricated with compounds of tar, a skin lesion is often set up, either in the form of the so-called "tar acne," characterized by black tarry points in the center of each papule, or a diffuse dermatitis, sometimes passing into an eczema. *Sewing-girls*: The irritation of the needle may excite an eczema of finger. An eczema or acne

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\* Ziemssen's "Handbuch."

† "Bulletin de l'acad. de méd.," xci, 803.

‡ See Bazin, "Affections cutanées artificielles."

rosacea may arise in those exposed to high temperatures—bakers (baker's itch), engineers, cooks, blacksmiths, etc. Stokers and glass-blowers perspire profusely. Firemen suffer from pustular eczema of the lower extremities. A tawny condition of the skin obtains in those exposed to much sun and light. Soldiers, sailors, vine-dressers, road and field laborers, coachmen, bricklayers, stone-masons, watermen, etc., may have a bronzing of the skin from exposure, the arms as far as the elbows, and the legs to the knees, being affected (erythema calorica, chloasma calorica). Shoemakers and tailors are prone to scabies, especially on buttock, owing to their sitting so much. Shoemakers and cavalrymen in Austria suffer much from *tinea circinata inguinalis* (Hebra) from like cause. Excessive horseback-riding, bicycling, and walking may excite a dermatitis. In summer, fleshy persons obliged to work in the heat of the day, and in winter, workmen who keep their shops very hot, suffer from sudamina, which, if unattended, may turn into a moist eczema. In Japan, Chinese lacquer-workers, in the varnishing of which the rhus vernix is employed, sometimes suffer from erythematous and vesiculous eruptions (varnish poisoning). Oil and sugar refiners (grocer's itch). Paper manufacturers and kid-glove makers may suffer from a dermatitis or eczema; tanners, from ecthyma and anthrax.

*Indirect Influences.*—Posture, bad drains, air, light, and damp. *Posture:* Literary men and ordinary penmen (clerks, book-keepers, etc.) are sometimes affected indirectly by their mode of sitting at the desk or table. Sitting at a low desk in a bending position so that the front part of the body rests upon the edge of the desk is very deleterious. Pressure is made on stomach and liver, and, if long continued, tends to interfere with the function of these organs and leads to dyspepsia, a frequent cause of skin disease. Any occupation that leads to repeated or prolonged congestion of the head may excite or aggravate an acne. Dr. Bulkley, in his admirable work on acne, cites a case in point of acne rosacea—that of a person engaged in a shoe-store. The continued stooping rendered her disease practically incurable. Whenever she gave up her work, treatment would be successful, but the acne invariably returned when she re-engaged in it. Those sitting with their heads bent forward—readers, sewing-girls doing fancy work, etc., especially near a hot light—may likewise suffer. Excessive use of the sewing machine may, perhaps, set up some uterine trouble, and this in turn give rise to acne. A sudden change of occupation from an active to one requiring confinement to the house may result in an eczema state (Bulkley).\* Bad drains, light, air, and damp in factories etc., tend to cause and keep up skin affections (furunculosis, etc.). The treatment consists in dealing with the lesions on dermatological principles, in protecting the parts with bandages, masks, rubber gloves, etc., remedy-

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\* "Eczema and its Management."

ing the posture, seeing to the sanitary conditions of the factory, and, as a last resort, in change of occupation. Some one has said, "Tell me who your friends are and I'll tell you what you are." This might be applied in many cutaneous affections, in a medical sense, with considerable truth. Tell me your occupation and I'll tell you your complaint. Occupation, then, plays an important part as an ætiological factor in a skin disease, and tends to subscribe to the doctrine of Herbert Spencer—that man is the creature of environment.

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### CLINICAL REMARKS ON PERFORATING ULCER OF THE FOOT.

By JOHN A. WESSINGER, M. D.,

Howell, Mich.,

Member of the Michigan State Medical Society, and Corresponding Member of the Detroit Medical and Library Association.

I AM well aware that perforating ulcer of the foot is a somewhat rare and obscure disease, and its ætiology at present very imperfectly understood. My own opinion is that perforating ulcer of the foot is the result of constitutional disease in which denutrition is a prominent feature. The treatment of the disease, barring surgical procedures, is quite unsatisfactory. The most recent views held by authorities on the nature of this malady, its pathology and treatment, are doubtless familiar to all, and need not, therefore, be rehearsed on this occasion. I will therefore simply deal with the clinical facts as they appeared in a case which has been under observation for quite a long time, together with the methods of treatment pursued and the results obtained.

Mrs. R., aged sixty, had been healthy until about fifteen years ago, when she began to manifest symptoms of diabetes mellitus. Her urine was examined chemically at this time, and the presence of small quantities of sugar recorded. The patient did not resort to treatment, however, until about four years ago, when the peculiar condition known as perforating ulcer of the foot began to manifest itself. The disease first began in the center of the plantar surface of the left foot. Its first appearance was marked by a red, slightly elevated, tumefied, circular spot. After a few weeks' duration this gave way to an excavating ulcer, which continued its progress until a probe could be passed completely through the foot. On several occasions spicula of bone were exfoliated from the metatarsals. This ulcerative process would continue through the winter months in spite of all treatment. Repair would, in turn, set in with approaching spring and summer, so that by early fall not the least vestige of the previous destructive process could be found; the diabetes, on the other hand, continuing uninterruptedly. The patient first came to my personal notice one year ago; prior to this time she had been under the care of Dr.

Wells, to whom I am largely indebted for the above history of the case. At the time I first saw the patient she was markedly diabetic; the daily quantity of urine was one hundred and forty ounces, five per cent. of which being sugar. Her body weight had diminished one hundred pounds in two years. The ulcerative process had quite effectually destroyed the usefulness of the left foot. The patient gradually became weaker until January 1, 1888, when she took to her bed. I kept the patient upon an antidiabetic diet, gave her internally full doses of codeine and hyoscyamus, and treated the ulcerating surfaces with iodoform and boric acid night and morning. Her condition remained about the same until March 1, 1888, when she suddenly developed a violent mania, which continued until April 1st. On this date Dr. E. L. Shurly, of Detroit, Mich., saw the patient with me, and advised the codeine continued, together with hydrogen peroxide and hyoscyne hydrobromate, gr.  $\frac{1}{480}$ , internally. Local applications continued same as before. Patient gradually regained her normal mental state. The ulcerating process in the foot became arrested, healing progressed well, and the patient was again sitting up by June 1, 1888. The diabetes in the mean time continued unmitigated in its progress. With this last repair in the left foot the same destructive process began in the right, the same perforating character of the ulcer being present as before. Small spicula of bone, in appearance like the crusts in a tea-kettle, were removed by myself on several occasions. At the present time, December 11, 1888, while the left foot is healed, the disease in the right has gone from bad to worse, until the usefulness of the member is completely sacrificed. So far as I have been able to search the literature on this subject, I find no record of the occurrence of perforating ulcer of the foot as a complication of diabetes mellitus. I am led to believe, therefore, that the association of these two maladies is somewhat rare. That this lesion should occur in diabetes is not strange when we remember the frequency with which destructive changes overtake the tissues in this disease.

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#### A CASE OF MULTIPLE MOLLUSCUM FIBROSUM.

By E. T. TAPPEY, A. M., M. D.,

Surgeon to the Harper Hospital, Detroit, Mich.

**I** SEND herewith a photograph of a very beautiful example of molluscum fibrosum. The patient is a colored man, aged thirty-two, by occupation a laborer; he has been filling the position of fireman on one of our ferry-boats for the past three or four years. He thinks the large tumor which is shown in the photograph has been developing ever since birth; that there was a small tumor in that part of the body when he was born.

The surface of the entire body is covered with tumors of different sizes, from the size of a pin's head to that of an English walnut, and that of the large tumor, which weighed, after removal, six and a half pounds. Patient



appeared at Harper Hospital, February 20th, and I amputated the large tumor under chloroform. The tumor was a large fibrous mass, suspended in a bag of skin, the pedicle being skin and large blood-vessels, nerves, and fibrinous gelatinous tissue. The only delay and annoyance during



the operation was the number and size of the arteries that it was necessary to tie. The tumor was a great hindrance, for it was heavy, and, being pendulous, shifted its position with every movement of the body. The man left the hospital at the end of a week very much relieved.

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 188TH REGULAR MEETING.

DR. E. L. KEYES, *President, in the Chair.*

**Trichophytosis Corporis.**—DR. JACKSON presented for Dr. G. H. Fox a case of this affection located upon the face and neck of a man. The disease had existed for nine months upon the neck and two weeks upon the face. On the neck the ring was large and irregular in shape, involving nearly the left half of the neck, and a small one on the right side of the neck. On the face there were two or three smaller rings, but still much larger than commonly met with. The patch on the left side of the neck had a markedly pronounced border, but inside of this the disease occurred as a great number of isolated red spots. On the face, the color, shape, and outline of the patches bore a striking resemblance to those of erythema multiforme.

DR. BRONSON thought that the large, extensive rings were formed by the confluence of smaller ones.

**Squamous Eczema of the Palms.**—DR. JACKSON presented for Dr. Fox a case of this eruption in a man. The lesions bear in some points a striking resemblance to syphilis, having a scalloped edge, with a worm-eaten appearance, and occurring not as a continuous patch, but as a number of isolated patches. Upon the backs of the hands there are some frank eczematous patches, and both palms are involved. Upon the left elbow there is also an eczematous patch. The disease is of two years' duration. There is an indefinite history of eczema in childhood; also of having had a chancre two years ago, followed by a general eruption, sore throat, and sores in the mouth.

In the discussion DR. ALLEN stated that he thought the eruption was a syphilide.

DR. BRONSON did not think that the essential element in the case was syphilis, but eczema. Syphilis would not produce the ragged desquamation seen here. He did not understand why it should be so symmetrical if it was syphilis. He mentioned how eczema seems to evoke infiltration in syphilitic subjects, and that other diseases can also do the same.

DR. KLOTZ thought that the eruption is syphilis and that the effect of the patient's work had something to do with the shape. He had seen a similar condition in cabinet-makers.

DR. CUTLER thought the affection was eczema in a syphilitic patient. The affection of the nails and the itching pointed to eczema, as likewise a patch on the foot.

DR. ELLIOT stated that he regarded the eruption as a papulo-squamous palmar syphilide. There might be some eczema present on the patient, but on the hands the lesions were due to syphilis. The scalloped border, composed of separate infiltrated lesions, the convexity of the border, and the patches of normal skin on the concave surface, suggested a serpiginous palmar syphilide.

DR. KEYES considered the eruption as a papulo-squamous syphilide, but he thought the patch on the foot resembled an eczema. He remembered one patient he had had in whom an identical eruption was present on one hand, which required four or five years' treatment before it got well, the stubbornness of the eruption being due to an impaired nutrition of the skin from a previous fracture of that arm.

DR. JACKSON, in summing up, stated that he thought the symmetry of the eruption spoke for eczema. This latter was certainly present on the backs of the hands. Moreover, the patient's hands were constantly wet. He had had mixed treatment and a variety of forms of local treatment for two years.

DR. KEYES said that the stubbornness to treatment of palmar syphilides was a well-recognized fact. He could recall another very similar papulo-squamous eruption on the palms in a patient who lived rather fast. When he stopped drinking it got nearly well, but relapsed again on beginning to drink. Finally it got well under heavy internal and local treatment. Two years later the patient had again a relapse and went to the Hot Springs, and at length got well.

DR. KLOTZ had found the palmar syphilides most obstinate to treatment, but had finally obtained cures by the injection, hypodermatically, of a solution of hydrarg. oxid. rubrum, 1:50 in 30.

DR. ELLIOT mentioned a case which would, in his opinion, show that Dr. Unna's view of the combination of seborrhoeic eczema and syphilis was of some value. A patient under his treatment acquired his syphilis a year and a half ago; general symptoms of the disease followed the chancre. About nine months ago he developed a papulo-squamous syphilide of both palms which ran a distinct chronic serpiginous course. After the appearance of Dr. Unna's article, the patient was given iodide of potassium internally, forty grains daily, and the ungt. sulphuris locally. In two weeks and a half the eruption disappeared. Previous to that the patient had had innunctions, mixed treatment, iodide of potassium, a hundred to a hundred and fifty grains daily, and local mercurial treatment, etc., without any benefit.

**Psoriasis followed by Dermatitis Exfoliativa (?)**.—DR. BRONSON presented the case from Charity Hospital, exhibited at the previous meeting of the society by Dr. Allen. The case then showed a disseminated pustular eruption, supposed to be due to applications of chrysarobin. The patient was psoriatic. Dr. Bronson reported that the pustules gradually disappeared, their sites becoming covered with loose scales. This scaly condition continued to spread at the peripheries of the lesions, with reddening of the surface and confluence of the lesions. In a short time almost the entire surface

of the body had become affected with deep-red congestion, attended with profuse desquamation. The desquamation was both branny and lamellar, and the patient's bed was filled with scales. There was some thickening of the skin, with considerable pruritus. When presented, this desquamation had become slight, but the intense congestion still continued. There were here and there still remaining patches of psoriasis. The case was presented as a form of dermatitis exfoliativa supervening upon psoriasis of long duration. The itching was very severe, especially at night. Under emollient applications, with arsenic internally, there had been considerable improvement in the appearance of the skin, though the irritation still continued.

DR. ALLEN, in discussing the case, said that he would regard it as an exfoliating form of dermatitis, but not a true dermatitis exfoliativa. He would refer to Dr. Morrow's case of pityriasis rubra with pustular lesions, presented to this society. He did not consider cases of dermatitis induced in a psoriatic patient by irritation as a true example of either dermatitis exfoliativa or of pityriasis rubra.

DR. KLOTZ thought that a sure diagnosis could not be made immediately.

DR. JACKSON considered the case as one of psoriasis and dermatitis combined. He would ask if dermatitis exfoliativa and pityriasis rubra were considered by the members of the society as the same disease.

DR. ELLIOT said that he would regard the case as one of acute diffuse psoriasis. He saw no reason why an ordinary dermatitis could not arise in a psoriatic patient which would be accompanied by excessive desquamation owing to the psoriatic base. The case presented at the one hundred and seventy-fifth meeting of this society, with symptoms similar to the one shown this evening, afterward came under his treatment and was cured in a short time by tar locally applied. He had excised a portion of the skin and examined it under the microscope, but the appearances were only those found in psoriasis, with a slight increase in amount of infiltration of the tissue. If these cases were dermatitis, with rapid and acute extension, he would expect elevation of temperature and general systemic implication, which, however, was not the case in any of the patients shown. He considered dermatitis exfoliativa and pityriasis rubra as distinct diseases; the acute cases as described by Erasmus Wilson, with fever, severe systemic symptoms, running a course of a few months, and almost invariably ending in recovery; and then there was the pityriasis rubra as described by Hebra, which run a slow chronic course, invariably ending in death. He had had one case of the former and two of the latter under his care, and he could not possibly see any connection between them.

DR. ALLEN considered dermatitis exfoliativa and pityriasis rubra as distinct one from the other.

DR. BRONSON, in summing up, said that the term dermatitis exfoliativa included a number of diseases with redness, acute and rapid spreading, and great keratolysis. Dermatitis exfoliativa in children was sometimes local and sometimes universal. The process would seem quite common in those having psoriasis, but still, in his opinion, it was totally distinct from that disease. He had seen a case corresponding to the one presented to-night, in which there

was redness, abundant desquamation, a great deal of prostration, and confinement to bed for a space of two months. Later on, distinct patches of psoriasis developed on the patient, in that case the dermatitis exfoliativa preceding instead of following the psoriasis.

**Dermatitis Herpetiformis.**—DR. BRONSON presented a case of this affection in a male patient, twenty-six years of age, born in Austria. From childhood he had suffered from irritable eruptions of the skin, which for the past two years had been much worse. When first seen by Dr. Bronson, a month ago, the body was found pretty well covered with an eruption, which was of an inflammatory character, and consisted of multiform lesions, which were vesicular, bullous, pustular, papular, and crusted in places. Notably the lesions seemed to occur in groups. Here and there they were confluent, causing crusted patches, with some thickening, that resembled eczema. The essential efflorescence appeared to be vesicular, though the vesicles were not always easy to demonstrate. Upon the palms and soles, as well as on the wrists and other places, the lesions were distinctly bullous or pustulo-bullous. The grouping was pretty well defined, though the eruption was distributed over almost the entire body. Nowhere was there any such decided thickening or diffuse redness of the skin as would be expected from an eczema.

In the discussion DR. ALLEN said that he could not agree with the diagnosis. He had formerly treated this same patient, and he had then suffered from an eczema rubrum. At times also there was much infiltration and the skin was very thick. What he considered as examples of dermatitis herpetiformis were so totally different that he could not reconcile this case with them.

DR. KEYES did not think it was eczema from the present appearances of the case. The isolated bullae, the want of tendency to become diffuse, the getting better in summer and worse in winter, would speak against eczema, in his opinion.

DR. BRONSON stated that eczema is not seen lasting from childhood to adult life, as the eruption in this case had done. Moreover, the present eruption is not diffuse; the lesions are grouped and occur in various forms, differing from ordinary eczema. There were very irritable papules associated with vesicles and bullae. He had not seen such symptoms in eczema. But the eruption agreed with dermatitis herpetiformis in its long continuance, the constant recurrence of grouped lesions without consequent thickening of the skin, and in the intense pruritus.

**Case for Diagnosis.**—DR. KLOTZ presented a patient, Louis K., fifty-four years of age, married, and the father of ten children, the youngest of which is eighteen months old. He has had for about three years an eruption on both hands which greatly interferes with his trade as a shoemaker. He denies ever having had syphilis. The eruption is confined to the back of both hands from the wrist to the knuckles, and to the whole aspect of the left wrist and lower third of forearm. It consists of several patches of a dull red—in some places bluish-red—and of irregular outlines, which, however, everywhere show distinctly gyrated and serpiginous characters, particularly on the patch over the left wrist. These patches are raised considerably above the surrounding healthy tissue, on some parts at least half an inch, repre-

senting ridges with well-defined but not very abrupt edges. The surface of the ridges is partly covered with dry, hard, but thin crusts which adhere quite firmly, partly showing a distinctly papillary structure. No pus or other discharge can be noticed by squeezing the affected parts. Between the ridges here and there portions of depressed cicatrized skin can be found. The patient was put on mixed treatment internally, and locally the mercurial soap plaster was applied nearly continuously. Within ten days, after taking in all about three grains of the red iodide of mercury and three drachms of potassium iodide, the patches have been greatly reduced in height and extent and promise to disappear within a short time. The case is presented—

1. On account of the uncommon and peculiar appearance of the lesions.
2. On account of the diagnosis, which seemed to lie between lupus erythematosus and dry tubercular serpiginous syphilis, the great improvement since treatment was begun speaking greatly in favor of its specific origin.
3. To show that papillary growths may develop on very different pathological conditions, particularly under the influence of repeated insults and irritation, representing rather a symptom, while a papilloma proper does not really exist.

DR. ALLEN stated that he would regard it as syphilis, though he thought it was of a peculiar form and color.

DR. JACKSON would exclude syphilis on account of the symmetrical appearance of the lesions. It reminded him of tuberculosis cutis verrucosa, a form of scrofulide. With this it agreed in its chronic course, color, and warty character.

DR. ELLIOT would consider the lesions those of tuberculosis cutis verrucosa. The warty character was very marked, and it seemed to him that the small lesions grew larger peripherally and became warty. A lesion on the finger about the size of a twenty-five-cent piece looked to him very characteristic. The lesion was oval, warty, and involution was beginning in the center. He thought that for syphilis the course of the disease had been too slow and limited to one surface, and the evolution and involution of the lesions were not such as were seen in that disease. He did not think that the effect of the treatment was conclusive, for mixed treatment influences favorably to a certain extent any chronic inflammatory process, and the local application would also have benefited the tuberculosis cutis verrucosa.

DR. KEYES considered the affection as a syphilide, though he had never seen an infiltrated tuberculo-squamous syphilide on the hands, but he had observed them on the face. The course of the lesions was to leave atrophy of the skin and not to ulcerate when not treated. The appearances at the wrist in Dr. Klotz's case were the most typical. He did not think that the local mercurial treatment would have produced so much good in a lupus. The symmetrical appearance was not so very unusual. In late specific onychia he had quite often seen symmetrical lesions. He would advise only internal treatment in the present case.

DR. KLOTZ, in summing up, said that the improvement under treatment had been so great that he would regard the lesions as due to syphilis. The papillomatous character had been much more marked than at present. The diagnosis of syphilis had also been based upon the character of the lesions on

the wrist. The absence of suppuration he thought would differentiate them from those of tuberculosis cutis verrucosa, in which it was always present.

DR. ELLIOT said that the pus which welled up on pressure in tuberculosis verrucosa cutis came from miliary abscesses. These abscesses were the result of a secondary infection with *Staphylococci pyogenes*, and consequently not an integral part in the disease, which was caused by the tubercle bacillus. This latter produced caseous degeneration, but not pus.

DR. ALLEN reported that the scales from the rings on the legs presented at the last meeting had been examined carefully under the microscope, but none of the fungus of ringworm could be found.

DR. ROBINSON stated that he would like to report to the society the last history of a case of lupus erythematosus of twenty years' standing which he had shown several times. The patient had a sore ear and was attacked by erysipelas, which lasted for two weeks, and under its influence the lupus erythematosus disappeared. The man remained well for two weeks, then developed secondary abscesses, which were followed by pyæmia and death.

DR. PIFFARD called the attention of the society to the fact that it was proposed by the pharmacists in the "Digest of Criticisms on the United States Pharmacopœia," 6th decennial revision, 1880, to use petrolatum as a base for the preparation of all official ointments. He said that his experience was adverse to vaseline as a soothing ointment, and he asked if the society regarded vaseline as an appropriate base for unguenta.

DR. TAYLOR did not think the question could be answered yes or no. Sometimes it was soothing and sometimes irritating. He had found that it decomposed rapidly.

DR. BRONSON did not think that it was irritating, but it did harm by macerating the skin. If it was made thick by the addition of other substances, he had found it to be soothing.

DR. ELLIOT had found vaseline both irritating and preventing the absorption of substances incorporated with it, and never used it.

DR. PIFFARD stated that inasmuch as vaseline irritated and prevented absorption when such was desired, he did not think that the proposition to use it as a base for ointments should be allowed to go unchallenged. He would object, among others, to its use in the making of the ungt. picis liquidæ, ungt. hydrarg., as it interferes with the absorption of the drug incorporated with it, and in the ungt. hydrarg. ammoniat., ungt. stramonii, ungt. hydrarg. oxid. flav., ungt. plumbi carbonat., etc., owing to its irritating properties.

The President, DR. KEYES, then called for a vote on the question, "Is it desirable to use vaseline as a menstruum for the preparation of official ointments which were intended to act in a soothing manner, or by the absorption of the drug incorporated in it?"

The unanimous vote of the society decided in the negative and against such use of vaseline.

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## Correspondence.

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### LETTER FROM THE EDITOR.

#### MATTERS OF DERMATOLOGICAL INTEREST IN THE SANDWICH ISLANDS.

**Demographic Effects of Introduced Diseases.**—The introduction of new diseases into a virgin soil, their growth and spread under changed conditions, and their influence upon the health and vitality of a new population, constitute a study of great interest to the medical observer. From this point of view the Sandwich Islands present the picture of a group of garden spots in the Pacific especially adapted to the cultivation of the exotic diseases of civilization. Of especial interest to the dermatologist is the study of the demographic effects of a quartet of introduced diseases—viz., syphilis, measles, small-pox, and leprosy. Transplanted to this soil, they have taken root and flourished with a rank and fatal luxuriance unknown in other climes.

Not only did the seeds of these diseases find a suitable soil, but their growth and spread were most assiduously cultivated by the natives—blindly and ignorantly, but none the less effectively. Their manner of life, their communism in the matter of eating and drinking and sleeping, as well as in their sexual relations, all contributed to spread and diffuse the germs of disease.

Syphilis was the first gift of civilization to the Hawaiian race, but, unlike the gifts of the Greeks, it excited no distrust or dread. Favored by the licentious habits of the people, it spread like a flame through the islands, and multitudes died from its effects or survived with impaired physique and broken health. The effects of syphilis are not to be measured by the direct loss of life it occasioned. To its agency are attributed the loss of the procreative power in the native observed during the last two or three generations and the enfeeblement of the offspring, which results in their premature death. When measles was first introduced it attacked men, women, and children of all ages, and nearly every case proved fatal. The ravages of small-pox were none the less frightful. In most of the districts where it was introduced, half of the native population perished. Leprosy, though slower in its spread and less rapidly fatal in its effects, is feeding like a cancer upon the life of the nation, and, unless checked, threatens its ultimate extinction.

**Skin Diseases among the Hawaiians.**—Diseases of the skin are comparatively common in the Hawaiian race, and it is interesting to note the modifications impressed upon the physiognomy of a familiar disease by race and climate as well as by the peculiarities of texture and darker color of the skin. The aquatic habits of the natives and the almost universal custom of frequent bathing would seem to afford protection against certain diseases which are almost invariably associated with uncleanness and filth, yet parasitic diseases are, according to my own observation and the testimony of the resident physicians, the most common cutaneous affections met with. Scabies is the

great pest among the natives, often occurring in the most aggravated form, with pustular and ecthymatous lesions. Chromophytosis is also quite prevalent. In the cases that I observed the spots are mostly discrete, with little tendency to aggregate into large patches. Favus is comparatively a rare affection. Eczema, unassociated with scabies as an exciting cause, does not form nearly so large a contingent of skin diseases as with us. According to Dr. McKibbin, the surgeon of the Queen's Hospital, psoriasis is more common than eczema. This observation may be based exclusively upon hospital experience, and consequently misleading. The dermatological wards of Charity Hospital would probably show more cases of psoriasis than of eczema; but in dispensary or private practice the proportion is reversed.

**The "Ava" Skin.**—The "ava" skin disease, peculiar, I believe, to the inhabitants of the Pacific islands, greatly excited my interest. I first observed examples of this peculiar condition among the lepers, who take "ava" for its fancied virtues as a remedy against this disease. The "ava," be it known, is a slightly narcotic, intoxicating drink made from the root of the ava or "kava-kava" (*Piper methysticum*), which has been highly recommended as an "anti-blennorrhagic." Its irritant effects upon the skin are manifest in the production of redness and dryness of the surface, with exfoliation of the epidermis in the form of white, branny scales. Sometimes the scales are the size of the finger-nail or larger, and are so abundant that a considerable quantity may collect in the clothing or bed at night. The skin is loose and wrinkled from an apparent absorption of the subcutaneous layer of fat. Incidentally, it may be said that "ava" is supposed to be a most efficient remedy against corpulency, and, from my observation of its superficial effects, I should judge this claim to be well founded. Its peculiar effect upon the nutrition of the skin probably results from constriction of the capillary vessels. In old ava drinkers the entire body becomes emaciated and the skin is covered with large scales, which, upon falling, may leave ulcerated surfaces, resulting in permanent scars. After prolonged cessation of the use of the drug, the skin may gradually return to its normal condition.

**Syphilis.**—As before intimated, syphilis has been one of the principal factors in the depletion of the Hawaiian race, which, in a little more than a century, has decreased from 400,000 to less than 40,000 people; but while this Samson formerly slew his tens of thousands, he is now shorn of his malignity and wears quite an inoffensive expression. Syphilis in the Sandwich Islands at the present day is—thanks to the principle of hereditary immunity—essentially a mild disease. In almost all the cases observed by me the manifestations were slight and superficial, with no destructive tendency. Hereditary syphilis is remarkable by its rarity. Living children are seldom born to syphilitic Hawaiian parents; if pregnancy occurs, it almost always terminates in miscarriage or a still-born child. The Sandwich Island syphilitic, unlike the poet, *fit non nascitur*, and, owing to the debauching influences with which youth is surrounded, he is often made a syphilitic at a very early age.

**Leprosy.**—To the dermatologist the medical interest of these islands centers in leprosy, and since my arrival I have devoted most of my time to making personal observations of this disease, which should serve as the basis of a



report before the Paris International Congress of Dermatology and Syphilography. I have been more especially interested in certain practical points relating to the aetiology of the disease, the various modes of its propagation, the period of its incubation, the degree of its contagiousness, and its therapeutics.

Upon all these points it must be confessed that the teachings of science are by no means fixed and definite. After centuries of study and observation of a disease which is as old as humanity itself, the only point upon which the verdict of experience is practically unanimous is that it is incurable. The treatment of leprosy still remains the despair of medical science, and it is a question whether the boasted knowledge of the nineteenth century has formulated more efficient rules for the suppression of the disease than are contained in the prescriptions of Leviticus. From a humanitarian point of view, the Hawaiian Government has improved upon the Mosaic method of enforced isolation. While it has adopted a vigorous and energetic policy in its efforts to stamp out leprosy by a rigid system of segregation, it deserves all praise for the generous and even munificent support it gives to these poor outcasts from society. All suspicious cases are kept under surveillance, and all persons presenting positive and indubitable manifestations of the disease are at once sent to the leper settlement, irrespective of their nationality or social and business position.

In no other country is so large a proportion of the population affected with leprosy, and in no other spot are congregated so large a number of the victims of the disease as at the leper colony of Molokai.

It may be of interest to your readers to describe somewhat in detail the workings of the system which the Board of Health has adopted in its dealings with this problem which so seriously threatens the health of the entire Hawaiian people, and which has already proved an important factor in the depopulation of these islands.

There is at Honolulu, the principal seaport and the seat of Government, a reception hospital, to which are sent from the various islands all persons known or suspected to be lepers, to be examined by a board of physicians appointed for that purpose. This duty of gathering the lepers is performed by a police officer or agent of the Board of Health, usually upon the recommendation of one of the district physicians.

The commitment of a leper to the settlement at Molokai means the abrogation of all his civil and political rights, a divorce from his wife, a separation from his children. It is a consignment to a living tomb, from which he can never hope to escape. It is a step involving a great responsibility, and, in order to avoid any injustice or hardship to the individual which might result from an erroneous diagnosis, every possible precaution is taken to guard against mistakes. With this view the following resolution was adopted by the Board of Health :

*"Resolved*, That no person shall be consigned to the leper settlement at Kalawao without his having been declared to be a confirmed leper by at least three competent physicians."

The committee of inspection consists at present of the president of the Board of Health, Dr. Emerson, Dr. Trousseau, and Dr. McKibbin—all old resi-

dents of the islands, and each of them thoroughly familiar with every phase and feature of the disease. Blanks, containing the name, sex, age, nationality, and residence of each person to be examined, are filled out, and the patients are admitted, one by one, and carefully examined. If there are doubtful indications present, their significance and bearing are discussed. Each examiner then fills out, opposite each name, his opinion, which is either "a leper," "suspicious," or "not a leper." These blanks are then signed and compared. If a patient has been adjudged a leper, he is sent by the next boat to Molokai; if suspicious, he is detained under surveillance at the Reception Hospital as a suspect, or sent home and ordered to report at stated intervals until the suspicious symptoms have cleared, or positive evidences of the disease are manifest; if declared a non-leper, he is dismissed.

In order to avoid the possibility of an unjust sentence and to make assurance doubly sure, a medical commission, appointed by the Board of Health, visits the leper settlement at stated intervals and re-examines persons enrolled on the list as lepers who are thought by themselves or others not to be lepers.

I was present at a number of these examinations, and was impressed with the thorough diagnostic ability displayed by the different members of the board, and the spirit of judicial fairness which controlled their actions. If there were doubtful or complicating elements present, which might be interpreted in favor of the non-leprous character of the disease, the patient was given the benefit of the doubt.

Ordinarily the symptoms of leprosy are so plain and unmistakable that no difficulty is experienced in arriving at an opinion, but in some cases, especially of the macular type, confusion arises, and it requires a nice judgment and a thorough acquaintance with the incipient evidences of the disease to discriminate between a leprous macule and an erythematous eruption due to other causes.

One element of error is encountered in making these examinations which would hardly suggest itself to an outsider, and which, being suggested, is scarcely credible. Sometimes a native will endeavor to simulate the disease in order to be sent to the leper settlement. With an irritant or discutient he will produce discolorations of the skin which resemble the port-wine discolorations characteristic of the commencing stage. This is often very artistically done, and the simulation is most admirably deceptive.

The motives for such action are various; it may be that he has leprous relatives at the settlement, and he prefers to die with them than live without them. Or his motive may be less sentimental; he wishes to be declared a leper in order to have food and clothing furnished at the Government expense. The Hawaiian, be it understood, has not the wholesome horror of disease entertained by his more civilized brother; he ignores its contagiousness, and neither disgust nor fear leads him to shun his brother leper as a bearer of deadly contagion. Leprosy carries with it no social ostracism, and arouses no instinct of self-preservation on the part of the patient's friends. It is this total absence of fear, this ignorant contempt of its contagiousness, combined with the promiscuous and intimate intercourse between the healthy and the diseased, which accounts for the rapid and unexampled spread of the disease

in these islands. Besides, the Hawaiian is somewhat of a fatalist; if he becomes a leper, he regards it as his destiny, and accepts his fate with not simply a stoical, but even a cheerful resignation.

**The Leper Settlement at Molokai.**—The origin of leprosy in the Sandwich Islands is involved in obscurity. According to the most authentic accounts, the first case was observed about the year 1845. The disease did not attract the attention of the authorities until the year 1864, when they awoke to the recognition of the fact that the spread of the disease seriously menaced the public health. In 1865 a law for the segregation of leprosy was enacted, and in 1866 the leper settlement was established at Kalawao, on the island of Molokai. At first only the confirmed and hopeless cases were sent to Molokai; the milder and less advanced cases were retained at Kaliki, near Honolulu; but later the latter hospital was abolished, and now all persons declared lepers are consigned to the leper settlement. The work of segregation has been carried out with varying degrees of energy and completeness under different administrations. Within the past year over five hundred lepers have been sent to the leper settlement, a much larger number than during any similar period of its existence. This does not necessarily indicate an alarming increase in the spread of the disease, but is due rather to an increased efficiency and activity on the part of the present Board of Health.

Since the establishment of the leper settlement about 4,000 lepers have been sent there, and at the present time there are about 1,050 inmates. These 1,050 by no means represent the entire number of lepers in these islands. Many whose existence and whereabouts are known are secreted by their friends or flee to their forest or mountain retreats whenever the Government police officer appears. The number of lepers at large March 31, 1888, was estimated by the Board of Health at about 650. This, in my opinion, falls short of the actual number. Probably more than five per cent. of the entire native population are lepers.

The location of the leper settlement is admirably adapted for the purpose. It is well watered, well drained, and constantly swept by the purifying breezes of the Pacific. It forms an admirable sanitarium. The accommodations provided for the lepers consist of neat frame cottages, with hospital buildings, dispensaries, churches, etc.

As this letter has already extended much beyond its proposed limits, I shall conclude with a condensed statement of facts of statistical interest. The leper population consists almost entirely of Hawaiians and half-castes. Less than three per cent. are Chinese, with a few other foreigners—British, American, German, etc., not exceeding perhaps a dozen altogether. There is a large excess of males over females, as is the case in every country where leprosy exists. As regards the type of the disease most prevalent here, the tubercular largely predominates, which is the reverse of the result of my observation of the disease in Mexico. Probably one half of the cases are tubercular, one third anæsthetic, and the remaining one sixth of the mixed type. The general impression is that the proportion of tubercular cases is gradually growing less, the modification or change of type indicating a progressive enfeeblement of the virulence of the disease. The statistics of the settlement show that leprosy is not so actively progressive and rapidly fatal

as it was twenty years ago. It is also claimed that abortive forms of the disease are now occasionally met with—that is, a patient will show slight but indubitable symptoms of leprosy, which after a time disappear definitively, the patient remaining ever afterward free from all signs of the disease. The very interesting facts which have come under my observation relating to the modes of propagation of the disease, its hereditary nature and contagiousness, I hope to lay before your readers at a future time.

MOLOKAI, March 7, 1889.

PRINCE A. MORROW.

*To the Editors :*

A member of the bar, distinguished alike for his eminence as a jurist and his profound general erudition, gave me recently the etymology of a familiar word that few can correctly spell and still fewer trace to its origin. He said the Roman diminutive *ette* contracted to *et* abounds in such words as streamlet, a little stream; rivulet, a little river, etc., while the Saxon diminutive *ock* serves a similar purpose in such words as hillock, a little hill, and bullock, a little bull, and plural, bullocks, little bulls. So it appears at last that the familiar name by which the schoolboy calls his testicles does not belong to the realm of slang, but descends to us straight from the shelves of mediæval classics.

E. R. P.

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## Selections.

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### Instruction in Dermatology and Syphilography in the German and Austro-Hungarian Universities; Henri Leloir, Professor of Cutaneous and Syphilitic Diseases in the Medical Faculty of Lille, France.

THERE are twenty universities in Germany, and in eleven of these there is given official instruction in dermato-syphilography. These are the universities of Berlin, Bonn, Breslau, Erlangen, Freiburg, Jena, Königsberg, Leipsic, Munich, Strasburg, and Würzburg. In Austro-Hungary there are eight universities having a medical faculty, and in all of these instruction is given in this branch by a professor who is the *chef* of a great special hospital service as well. These universities are in Vienna, Buda-Pesth, Prague, Gratz, Innsbrück, Klausenburg, and Cracow. In Prague there are two faculties, one German, the other Techeck. At Vienna there are several professors who teach dermato-syphilography.

The professors of this subject in Germany do not have as high a grade in the university as the professors of branches such as anatomy or pathology possess, and this is rightly regarded as unjust, because the men who occupy the chairs of dermatology and syphilography may be, and generally are, men of as great talent and learning as those occupying other chairs. The highest title of a professor conferred upon him by the university in Germany is "Ordinary Professor" of such and such a subject. The next in grade is "Extraordinary Professor," and the next lower is "Privat-Dozent." Now,

none of the occupants of the chair of dermato-syphilography in Germany have a title above that of "Extraordinary Professor." The instructors with this title do not form part of the number of examiners of candidates for the degree of M. D., and consequently the lectures they give are not usually followed by so large a number of students as attend the courses given by the ordinary or titular professor.

The *privat-docenten*, whose title about corresponds to that of the *professeurs agrégés* in France, but which has no exact equivalent in America, give courses of lectures, but form no part of the examining juries.

In the German universities, except that of Berlin, the chairs are mixed—*i. e.*, it is a chair of diseases of the skin and of syphilis. In Berlin, Professor Lewin teaches the purely venereal diseases at the Charity Hospital, while Professor Schweninger has the purely dermatological chair.

In Germany, as well as in Austro-Hungary, the university career of a student who ultimately arrives at the professorship is as follows: If he shows great zeal, intelligence, and ardor in work, the professor whose lectures and clinics he follows may take him for his assistant. This position he may hold for two, four, six, and even eight years, and he receives as salary about 1,000 marks, or nearly \$250, yearly. Then he becomes *privat-docent* by presenting some original work to an examining board, before which he has to sustain a severe examination as well. Here his relationship to the university begins. From this time on he has only to distinguish himself in some branch of medicine, and ultimately he will be called to a chair in some university of the country, or perhaps to some foreign faculty. As *docent* and as professor he is paid a small fixed sum by the state, but by far the larger part of his income is usually obtained through the lecture fees which each of his hearers pays, and which vary from \$5 to \$10 per semester.

In France, on the contrary, the professor of a faculty outside of Paris can not hope, under the existing regimen, to ever occupy a chair in the faculty of the grand capital. His aspirations are thus more limited than those of his German or Austrian colleague. The French professor reaches his position through the following degrees: *Externe, interne, chef de clinique, professeur agrégé*, and, lastly, *professeur titulaire*. The titular professor receives 15,000 francs yearly (about \$3,000) from the state and nothing at all from the students, so that the sum named represents all the income he receives as professor.

The interchange of professors between different universities in Germany and Austria is a common occurrence. A professor is not obliged to pass his life in one place. Even if the faculty of which he forms part is considered an inferior one, he may, by becoming sufficiently distinguished, be called to a more noted one, and may finally occupy a chair in the highest university in the land.

The power of the dermato-syphilitic instruction in Germany is largely due to excellent organization and to the mode of recruitment of the professors. These are always men who have made a high reputation for special learning and ability, and it is thus that they attract so large a number of students.

Professor Leloir considers the clinic of dermato-syphilography at Bonn to

be a model institution, while he thinks the teaching in Vienna errs in being so practical that it neglects the theoretical part of the science. The clinic at Bonn has fifty beds, which are divided into two sections—one for males, the other for females. Each of these are again subdivided into a section for skin diseases and a section for syphilis. Professor Doutrelepon, of Bonn, receives about \$240 yearly for the expenses of the clinic.

In Munich, where Privat-Dozent Carl Posselt has his clinic, there are forty-eight beds for women, one half of which are reserved for public women who are lodged apart from the rest; for men there are thirty-six beds for venereal diseases, twelve for cutaneous diseases, and twelve reserved for students.

In Austria the chair of dermato-syphilography is more highly honored than in Germany, in that the occupant may be an "ordinary" or titular professor. In this country the privat-docents are not officially charged to give courses on this subject, although they do give private courses, for which the fee is from ten to twenty florins, or from \$4 to \$8 per semester.

In Vienna, as in Berlin, there is a separate chair for purely cutaneous diseases, which is occupied by Professor Kaposi. The chair of syphilitic and venereal diseases is occupied by Professor Neumann. Kaposi's clinic is followed by a great number of students, often over a hundred, and Neumann has nearly as many. In the other faculties of Austro-Hungary the chairs are mixed.

The professors receive from the state the sum of from \$120 to \$300 for the expenses of the clinic (library, instruments, laboratory, charts, etc.). The students pay a fixed fee to every professor. It is not absolutely obligatory for the students to follow the lectures on dermatology and syphilography, but they do so because it may happen that the professor of these subjects may be one of the examining committee when they come up for their diploma.

Italy has made great progress of late years in dermato-syphilography. All her universities have a chair in this department of medical science.

### **Treatment of some Urethral Strictures by Section and Drainage.**

REGINALD HARRISON, who has already written upon combined external and internal urethrotomy, again brings up the subject in an able article in "The Medical Press and Circular" of February 6, 1889.

The advantages claimed for the double method are :

1st. That the method is applicable to the worst forms of urethral stricture, where the narrowing is so complete as to reduce micturition to the finest possible dimensions, and where necessarily only the smallest and most delicate instruments are applicable.

2d. It provides against rigors and fever and the complications that arise out of these.

3d. It tends to improve permanently the condition of the stricture.

The truth of Syme's statement, that "where urine could pass, an instrument should," the author has verified in a large hospital service as well as in private, and he ventures to say, at least to his juniors, "Learn to use soft instruments and you will not be long in finding out how seldom metal ones are necessary ; nor will your patients fail to appreciate your discovery."

The double operation is well adapted to the worst forms of stricture, involving the deeper or subpubic portion of the canal, but in the slighter strictures, where dilatation proves effectual in restoring the size of the canal and in maintaining the restoration by an occasional use of the bougie, he considers that all operative interference is entirely uncalled for. Bank's filiform bougie and Lister's probe-pointed graduated bougies are well spoken of, and in very sensitive patients, where a fine whalebone bougie can be passed, it is sometimes well to tie it in with a piece of silk and a plaster around the penis for forty-eight hours, and on removing it to introduce an ordinary "whip." A patient with a very tight stricture can, as has been shown, pass water well by the side of a very fine bougie. No stricture should be submitted to operation without a trial being first made by other measures, unless there be some special urgency. Maisonneuve's urethrotome is preferred when the stricture is neither thick nor dense, but when extensive and cicatricial he finds Watson's necessary. A pilot should always be fitted to the instrument, and he prefers the knife to run on the concavity. After performing internal urethrotomy, a staff is introduced and a perineal puncture is effected, Wheelhouse's probe-pointed gorget is slid along the groove into the bladder, and a drainage-tube inserted along the gorget into position. The bladder is washed out with a perchloride solution (1 to 5,000) and two or three ounces are left in the viscus. Half an ounce of carbolic oil (1 to 20) is injected into the urethra and well rubbed in where the internal section was made. A certain quantity of this oil will escape by the perineal wound. The plan of sterilizing the urine with boric acid for forty-eight hours before operation as well as subsequent to it, a method proposed by Dr. Palmer, of Louisville, Ky., is highly spoken of. He employs the following formula :

R. Boric acid.....	3 j ;
Sod. biborat.....	3 ij ;
Syr. tolu.....	3 iv ;
Aquæ.....	ad. 3 vj.

M. Cap. 3 ss. 4tis horis ex aqua.

Success of the double operation depends more, however, on the drainage than on antiseptics. A perineal section with a complete division of the stricture from without is in some instances by no means easy or free from risk. The position and length of the stricture are sometimes such as would require an unnecessary amount of perineal section to fulfill the conditions upon which such an operation is ever undertaken—viz., the division of the stricture and the making of an opening into the bladder which will drain. The double operation is advocated when the stricture is not merely confined to the urethral walls, but when the induration, of which it is a part, involves the perinæum and scrotum, with perhaps the addition of two or three fistulæ. In these conditions the writer believes there is no procedure at all comparable with this operation, which Syme perfected if he did not originate. If a stricture has been allowed to get into such a condition as to call for division from within by a cutting operation, then it is contended that the patient is safe immediately, and has a better chance of being permanently benefited, if at the same time temporary provision is made for an independent urine-drainage.

### Notes on the Surgery of the Kidney.

UNDER the above title Reginald Harrison discusses in the "Liverpool Medico-Chirurgical Journal," January, 1889, the following subjects: Nephrectomy, or extirpation; nephrotomy, or incision into a kidney; digital exploration of the kidney and its neighborhood; nephro-lithotomy, or removal of stone from the kidney; fixation of a movable kidney; and the exploration of a ureter.

Of *nephrectomy* he has but little to say. In two instances in which it was resorted to excellent results were obtained. He has not had recourse to it for conditions other than those associated with suppuration of the interior of the kidney. He does not favor it for malignant disease. His predilection is for the lumbar incision, though the abdominal method permits the operator to ascertain the presence of both kidneys. He had adopted the plan of ligaturing the pedicle in a mass without drawing distinctions between artery, vein, and ureter. Secondary hæmorrhage seems to be rare.

*Nephrotomy* is an expedient which should be resorted to in suppurative affections of the kidney before extirpation is attempted. The most favorable cases are those in which the abscess is limited to one organ, and has little or no direct connection with the ureter. He has met with cases where it became necessary to extirpate what remained of the suppurating organ. Unless the whole tract is removed the patient will inevitably sink, whatever may be the risk attendant upon the operation. It is important that the incision should correspond with the most dependent portion of the kidney abscess cavity, and that the line of drainage should be as direct as it is possible to make it. In suppurating tuberculosis of the kidney the author's experience has not been favorable, and nephrotomy is not advised unless the presence of a single abscess, which was not relieving itself adequately by the ureter, could be determined with precision. Attention is called to the importance of ascertaining, if possible, whether the corresponding ureter is patent after nephrotomy. This may be done by passing down it an instrument such as a bougie or by the injection of water. The history of a case of pyonephrosis due to a small malignant papilloma of the bladder obstructing the ureter is related to illustrate this point. The kidney was opened and drained, but blood continued to appear in the urine, and the patient died. If at the time of operation the obstruction to the ureter had been discovered, the true cause of the subsequent hæmaturia would have been more easily recognized.

*Digital exploration* the author has practiced on many occasions, and has thus obtained valuable information as a preliminary oftentimes to operative procedure. He has also advised and practiced digital exploration merely for the purpose of searching for the cause of painful symptoms which have resisted all other methods of treatment, and has never had cause for regret, but, on the contrary, good has always resulted. In making an exploration an incision is made across the lumbar region parallel with the last rib about four inches in length, commencing at the outer edge of the erector spinæ muscle. If nothing is found, a drainage-tube is inserted, the wound closed with sutures, and an antiseptic dressing applied.

*Nephro-lithotomy* has been resorted to on three occasions. In two in-



stances the calculi cut out of the kidney were small; one was contained in the pelvis and had induced hydronephrosis; the other was incased in phosphates in a suppurating calyx. Both these patients did well. In the third, two operations were performed, and calculi, weighing together two hundred and eighty-six grains, were removed, but the result was fatal, and it was thought that it might have been better to have removed the kidney with its contents at first.

Little is said of the two remaining operations, as no certain data can be given. Reference is made to Mr. Godlee's case, in which a stone was forced into the urethra by two fingers introduced into the vagina. The calculus had been previously detected by digital exploration of the bladder projecting from the lower end of the right ureter.

### **Pemphigus Vegetans.**

At a meeting of the Royal Medical and Chirurgical Society, March 12, 1889, Dr. H. Radcliffe Crocker read a paper on this subject. Only two previous indubitable cases, and those under a different name, had been recorded in this country, and only eleven others were known, all recorded by German observers.

The case now related was a typical instance. A woman, aged forty-three, unmarried, was first taken ill at the beginning of April, 1887, with stomatitis and great weakness. A few days later bullæ appeared on the abdomen, soon followed by others. Each bulla from the first, instead of healing, left an ulceration on its site, and in the axillæ and groins there was enormous papillary hypertrophy producing frambcesiform masses with a very offensive secretion. There was extensive denudation of the oral mucous membrane. The conjunctiva and vulva were also affected. Deglutition became more and more difficult, and, as fresh crops of bullæ kept on appearing, large raw areas were produced. The patient became gradually weaker, treatment producing no amelioration except in removing the offensive odor, and she died on July 9th, the disease having lasted three months.

A low form of pleuro-pneumonia was the only important visceral lesion. An analysis of this and thirteen other cases showed that the characteristic features of the disease were, that, without any previous illness or known cause, pain on swallowing and soreness of the mouth were experienced, due to the formation of bullæ on the oral mucous membrane. In a few days or weeks crops of bullæ, generally of the ordinary pemphigus type, appeared on the abdomen or elsewhere. These bullæ did not, as usual, dry up into a thin crust, but left superficial ulcerations on their site, which remained unhealed for a long time, and when they did, left deep-brown pigmentation. The ulcers were worst over points of pressure, such as the occiput, shoulders, sacrum, or hips. In the axillæ, groins, gluteal folds, and in the lower part of the abdomen—in short, in all the warm and moist situations—fungating papillary growths sprang up on the site of the ruptured bullæ, and might project from a quarter to half an inch above the surface, and secrete a very offensive muco-purulent fluid. Fresh crops of bullæ continued to develop; the mouth affection interfered with nutrition; the patient became progressively weaker, and died after a few weeks or months of exhaustion or some intercurrent inflammation.

Less common features were where the skin lesions preceded those of the mouth. In four instances there had been suppurative onychitis of all the fingers and toes, with shedding of the nails. In two cases there had been clonic convulsions with heightened reflexes. Ptyalism had been noted in three cases, and involvement of the conjunctiva and vulva had been generally noted. In spite of the most varied treatment, the disease had been uniformly fatal in all undoubted cases, though in one case recovery took place in the first attack; but the disease recurred some years later with a fatal result. If seen early, the administration of opium in full doses, as employed by Mr. George Pollock and Mr. Hutchinson, was worthy of careful trial.

Dr. Mapother mentioned a case which occurred under his care in St. Vincent's Hospital, Dublin, of pemphigus in a woman; the large flabby bullæ were followed by ulceration and the formation of papilliform excrescences. The disease was considered to be due to syphilis. The woman subsequently died after an illness of nine weeks.

Dr. Crocker, in reply, said that he was glad to hear of another case, and expressed a hope that it would be published.—*British Medical Journal*, March 16, 1889.

### The Treatment of Acne.

DR. ISAAC, assistant to Dr. Lassar's clinic for skin diseases in Berlin, discusses in the "*Berliner klinische Wochenschrift*," No. 3, 1889, acne and its treatment. As an aetiological factor in the production of acne, he considers that hereditary peculiarities in the opening of the sebaceous glands may have an influence. In such cases the sebaceous duct is wide and funnel-shaped, offering a nidus for dirt and other septic material. Though such anatomical peculiarities may in exceptional instances predispose to acne, its causes are to be sought for in disturbances of the digestive, circulatory, or of the generative apparatus. The treatment in vogue at Lassar's clinic is the following:

℞ Naphthol β.....	10·0;
Sulph. præcipitat.....	50·0;
Saponis virid.,	
Vaseline.....	āā 20·0.

This salve is applied thickly to the affected portion of the skin either by a brush or a spatula, and left *in situ* for from half an hour to an hour. On the following day one notices some desquamation of the epidermis and slight irritation and retraction of the skin. This procedure is repeated every day until desquamation of the entire epidermis has taken place. Should much irritation be produced, the treatment may be temporarily stopped and the affected surface covered with an indifferent powder or with Lassar's paste. For especially stubborn cases the following modification of the ointment may be applied:

℞ Pulv. cretæ albæ.....	5·0;
Naphthol β,	
Camphor,	
Vaseline.....	āā 10·0;
Saponis virid.....	15·0;
Sulphur præcipitat.....	50·0.

The addition of the camphor increases the irritative power of the ointment, which in this form should only be left on the skin fifteen minutes.

Another formula which has been found serviceable in the treatment of acne is the following:

℞ Resorcin,	
Zinc oxid.,	
Amyli.....	āā 5·0;
Vaseline.....	10·0

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## Items.

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**American Association of Genito-urinary Surgeons.**—The next meeting of this association will be held at Newport, on the 21st, 22d, and 23d of May, 1889.

It is expected that this meeting will be as full a success as the two previous ones have been.

**A Contribution to the Therapy of Lupus.**—F. Huber recommends in the treatment of lupus erythematosus, as well as lupus vulgaris, the external application of Fowler's solution, which he applies once daily. In cases presenting frequent congestion to the head he obtained good results from the internal use of ergotine.—*Wiener med. Presse*, xiv, 1888.

**On the Treatment of Lichen Ruber Planus.**—K. Hershheimer recommends in the treatment of lichen ruber planus the external application of a ten-per-cent. solution of chrysarobin in traumaticine, to be applied twice a week until the eruption has disappeared.—*Berliner klin. Wochenschr.*, 1888.

**Iodol in Tertiary Syphilis**, by Dr. D. Cervasato, of Padua.—In tertiary syphilis iodol gives very good results. In two cases in which deep and extensive syphilitic ulcers had formed from gummata in the fauces, on the soft and hard palate, perforation of the hard palate even taking place in one case, the internal and local use of iodol made a rapid and complete cure in about two months. Two to three grains *pro die* were given internally, and the following solution was applied locally:

℞ Iodoli.....	1 part;
Alcohol.....	16 parts;
Glycerini.....	32 parts.

In another case of tertiary syphilis with hepatic and laryngeal lesions excellent results were obtained from the use of iodol.—*Wiener klin. Wochenschr.*, vi, 1889.

**Treatment of Atonic Tibial Ulcers.**—Appenrodt recommends in the treatment of atonic tibial ulcers with callous edges a methodically performed massage. After the ulcer has been disinfected several days, the massage is begun below the knee. The ulcer itself is then only covered with gauze. If good granulations have formed, transplantation after Reverdin hastens the cure, but which also takes place without this procedure. The massage should also be continued after the healing of the ulcer. The extremity should be continually used during the treatment.—*Deutsche med. Wochenschr.*, 24, 1888.

**Dermatoses following Mental Shock.**—A lady, after witnessing a violent assault upon her husband, was much prostrated by the fright, and three weeks later a bullous eruption, having the characteristics of foliaceous pemphigus and accompanied by incessant pruritus, made its appearance. Another case was a little girl who was rescued from burning, and remained for some time in a condition of prostration from fright. A month afterward a pemphigoid eruption made its appearance on the body, disappeared under treatment, but reappeared again several times. A third case was that of a woman who became very much excited in a quarrel with her husband. A few days afterward an exudative erythema made its appearance on the arms, hands, and feet; and vesicles on the lips. E. de Smet has recorded cases of purpura hæmorrhagica from the same cause.—*Progrès médicale*.

**Phenic Acid in Malignant Pustule.**—Contento recommends very warmly the treatment of malignant pustule by means of hypodermic injections of a three-per-cent. solution of carbolic acid, from the very good results he obtained. This method has also been tried by Maffuei, Raimbert, Gallozzi, and others. He employed this treatment in six very grave cases of malignant pustule, of which he gives a full history. He injects the solution round about the center of the pustule about one centimetre removed from the line of demarkation at about one and a half centimetre from each other. Besides that, he injects a couple of syringe-fuls directly into its center.

The number of injections made at one sitting varies, according to the size of the pustule, from six to twenty-five. Usually after twenty-four hours such a striking improvement takes place that repetition of the injections is rarely necessary.—DR. CONTENTO, *Gazzetta degli ospitali*, xxviii, 1888.

**Plumbum Causticum in the Treatment of Condylomata.**—Bockhardt praises plumbum causticum in the treatment of condylomata, especially that of the cockscomb variety, as well as in the treatment of the small, distinct, pointed, and closely crowded together condylomata where this remedy effects a radical cure. It causes by its caustic action very small ulcers which heal quite rapidly. Bockhardt recommends the formula given by Gerhard, consisting of a 3·3-per-cent. solution of oxide of lead in a 33-per-cent. solution of caustic potash.—DR. BOCKHARDT, *Monatshefte für prakt. Dermatol.*, vi, 1888.

**Formula for treating Syphilis in Children.**—Schwimmer recommends the following:

℞ Calomel,  
Dover's powder.....āā gr. ij;  
Sugar of milk..... gr. xlv.

Divide into ten powders. One or two daily to a nursing child, and six to nine to a child over a year of age. This treatment may be continued from a month to six weeks at a course.

**Fissures of the Tongue.**—These obstinate and painful lesions may be speedily cured, according to Schwimmer, by applying the following mixture five or six times daily:

℞ Papayotine..... 2 parts;  
Glycerin, aquæ.....āā 10 “ M.

—*Revue de thérapeutique*, Oct. 15, 1888.

**Treatment for Burns and Frost-bites.**—In “*Monde de la science et de l'industrie*” Buboff reports sixty cases of burns and frost-bites successfully treated by his method, which consisted in the application of compresses of cotton or linen moistened with a solution of permanganate of potassium. The strength of the solution was from one to three grains to the ounce of water. The remedy is only efficacious to burns of the first degree, and to frost-bites of the first and second degrees.

# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

### A CASE OF KERATOSIS (ICHTHYOSIS) FOLLICULARIS.

By JAMES C. WHITE, M. D.,

Professor of Dermatology in Harvard University.

**T**HERE appeared lately at the clinic for cutaneous diseases at the Massachusetts General Hospital a patient whose skin presented the following extraordinary manifestations: The whole surface, with the exception of the palms and soles, the genitals, and some portions of the flexor aspects of the arms, was thickly occupied by a variety of lesions, which may be thus analyzed:

1. Minute papules, the size of a small pin's head, smooth, firm, and not differing in color from the surrounding skin.

2. Papules somewhat larger than the above and slightly hyperæmic in appearance.

Lesions 1 and 2 closely resemble those of keratosis pilaris, but are, perhaps, not so sharply conical as the latter often are.

3. Still larger papules, of flattened hemispherical shape, with smooth or polished, dense coverings of nail-like consistence, and varying in color from dull-red to purplish, dusky-red, brown, and brownish-black. At a little distance they strongly resemble the lesions of lichen planus. The tips of some of them have been excoriated by scratching and are covered by hæmorrhagic crusts.

All of the above three forms are discrete and are surrounded by apparently normal skin.

4. Extensive elevated areas formed by confluence of the above lesions, presenting uneven surfaces, covered by thick, yellowish or brownish, flattened, horny concretions.

5. Elongated, horny masses, from one half to one third of an inch in diameter, and from one eighth to half an inch in height, of irregular out-

line, with blunt, truncated apices, yellowish in color, of dense consistence, and compactly crowded. They may be removed with little difficulty, and then show bases of corresponding area, considerably elevated above the general surface, hyperæmic, and moist.

All these lesions thickly occupy the trunk and limbs, with the exception of some portion of the inner surfaces of the arms. The smaller discrete papules are distributed over the flanks and lateral thoracic regions, the flexor surfaces of the arms, and some parts of the legs. The larger forms, and the uniform areas made by confluence of the same, occupy extensive tracts upon the extensor portions of the arms, the anterior and posterior aspects of the trunk, and nearly the entire lower extremities. On the lower legs they form thick plates, completely encircling the limb, broken by deep fissures and shallow ulcerations. The most prominent horny prolongations are seated upon the median spaces of the trunk, front and back, and are most pronounced over the sternum and pubes. See accompanying plate from a photograph by Mr. Chadbourne, medical house pupil.

6. Smooth, flattened, blackish, elevated plates, forming a continuous covering upon the backs of the feet, and resembling the condition called, by some French writers, *ichthyose noire cornée* (vide Baretta's model No. 4).

7. Enormously dilated follicular openings, distended apparently by firm, slightly projecting conerctions, forming hemispherical elevations. These occupy nearly the whole surface of the upper parts of the face.

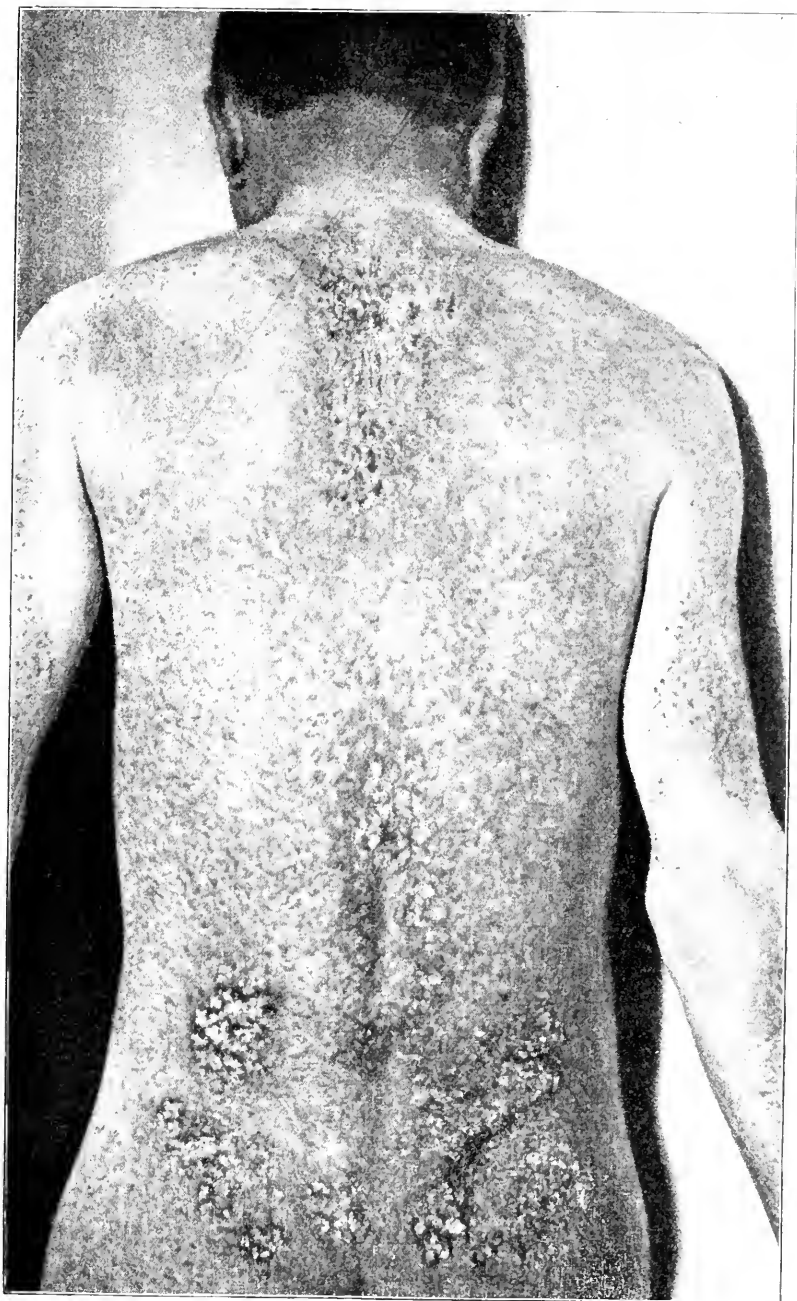
8. Small, sharply pointed, conical horns, curved at the tip, protruding an eighth of an inch from a few of the above distended follicles. These are situated below the eyes.

9. A few large circular elevations with blind central depressions, nearly half an inch in diameter, closely resembling a crateriform epithelioma, seated upon the temples.

10. Large papilloma-like excrescences, almost fungoid in appearance, nearly filling up the space behind the ears, and separated from each other by deep fissures.

Upon the scalp are some sparsely scattered, medium-sized, firm elevations. The hair growth is everywhere normal. The integument of the palms, soles, and genitals is but little changed from its natural condition. The nails are coarse, slightly thickened, and jagged at their free edges. A few firm, small, papular projections are seen upon the hard palate.

The skin is nowhere oversensitive or painful on pressure, excepting about the ulcers upon the lower legs. There is a nearly universal pruritus, which leads to almost incessant violent scratching, in consequence of which the horny elevations are frequently torn away, to be in turn slowly reproduced. An intolerable stench is given off by the patient, especially



from the lower legs, characteristic of decomposing epithelium. The clothes are saturated with it.

The patient gives the following account of himself : He is an American, forty-nine years old. His parents and an older brother are in good health. None of his family are known to have had any cutaneous disease. His skin was always natural until after entering the army in 1862, at the age of twenty-two. He underwent the usual inspection on enlistment, and no marked disorder, at least of the skin, was noted. The first sign of the affection observed by him was the appearance of "a rash" upon the shoulders beneath the knapsack after a long march. He says that it looked then like the smallest lesions now present. During the following two or three years "it spread a good deal" upon the trunk, but "no crusts appeared upon the pimples" until after this period, and then they began to form upon the back and front chest. Two or three years later the limbs began to be affected. Since that time there has been a gradual extension of the lesions over the whole integument, with progressive changes in character up to the present time.

The patient's general health has always been good, although suffering much throughout the disease from itching, and in later years also from the ulcerations upon the lower legs. The horrible odor emanating from the skin has lately kept him from free intercourse with his fellow-men.

What disease do all these extraordinary and multiple manifestations represent? It is easy to trace the intimate connection between the various lesions by their progressive development from the minute primary papule to the largest masses of horn-like concretion. At the beginning of the process we have lesions in no way to be distinguished from those of simple keratosis (*lichen*) *pilaris*, while the other extreme is characterized by formations resembling well-marked *ichthyosis cornea*. The disease is then, evidently, in all its phases a keratosis, or primarily a hypertrophy, or modified cornification of the epithelial layers. It is also evident that its starting-point is in or about the follicular openings. To determine the precise nature of the anatomical changes in the cutaneous tissues, specimens of the lesions representing various stages of development were removed by my friend, Dr. John T. Bowen, by means of the cutaneous punch of Dr. Mixer, and submitted to most careful microscopic examination. The processes employed and the results obtained are detailed by him in the following report :

"One of the horny concretions, nearly one centimetre in length, was removed from the abdomen, and two lesions were excised from the outer side of the upper arm, one of them a papule of less than miliary size, and chosen as representing the primary stage. Besides these, there was excised from the cheek, just below the eye, a well-developed lesion from which protruded a horn, about five millimetres in length and slightly curved at the end.

"The specimens were hardened in alcohol and cut in celloidine, with



the exception of the larger lesion from the arm, which was imbedded in paraffine.

"The horn removed from the abdomen was shown, in sections stained for some time in picocarmine, to be made up of epithelial cells, arranged more or less regularly in vertical or oblique columns, with a nucleus sometimes colored by the carmine, sometimes not. In places the cell structure had become almost obliterated, bands of fibrous-looking tissue having taken its place. Here and there throughout the horn were scattered bodies of a concentric arrangement, similar to epithelial pearls, which took on a bright-yellow tint from the picric acid. The base of this horn was not examined.

"The larger lesions were cut in sections through the entire nodule. The sections were stained in picocarmine, in hæmatoxyline and eosine, and in safranine to which aniline water had been added. The sections from the periphery of the lesion were noticeable chiefly from the prominence of the sebaceous glands. It could not be accurately determined whether or not they were increased in size, although it seemed probable that they were. They were perfectly normal in appearance. Advancing toward the center of the lesion, a proliferation and extension of the rete cells into the corium could be seen, and in the center the appearances were those represented in Fig. 1. The lesion described is the one taken from the cheek, and from which a horn five millimetres long protruded. The appearances were those of a pouch or sac, extending down into the corium, and separated, in its lower portion, into two subdivisions. Into this pouch extended the horn previously described, which had become detached from its base during the process of imbedding. The figure represents diagrammatically the portion of horn that protruded above the surface of the skin. The horny matter extended nearly to the bottom of the pouch, where the lower rete cells were enlarged and undergoing proliferation. Staining with hæmatoxyline and afterward treating with a one-per-cent. solution of hydrochloric acid, brought out very prominently the granules of the stratum granulosum, which were also well seen in the picocarmine specimens. The increased breadth of this layer, the large size, and irregular, branched shape of these keratohyaline granules, as seen in the hæmatoxyline and picocarmine specimens, taken in connection with the horny changes, suggested a careful investigation of the much-disputed keratohyaline-eleidin question, as illustrated by these pathological changes, but, unfortunately, the material was insufficient. At the periphery of the lesion a marked increase in the pigment in the normal rete cells was noticeable. The corium presented no features of pathological significance. The papillæ at the sides of the lesion were somewhat enlarged, and there was a moderate round-celled infiltration about the vessels. The sweat-glands were normal.

" From the two larger lesions no positive opinion could be reached as to the nature of this crypt or pouch in the corium from which the horn extended. Its shape suggested the enlarged orifice of a hair follicle, with

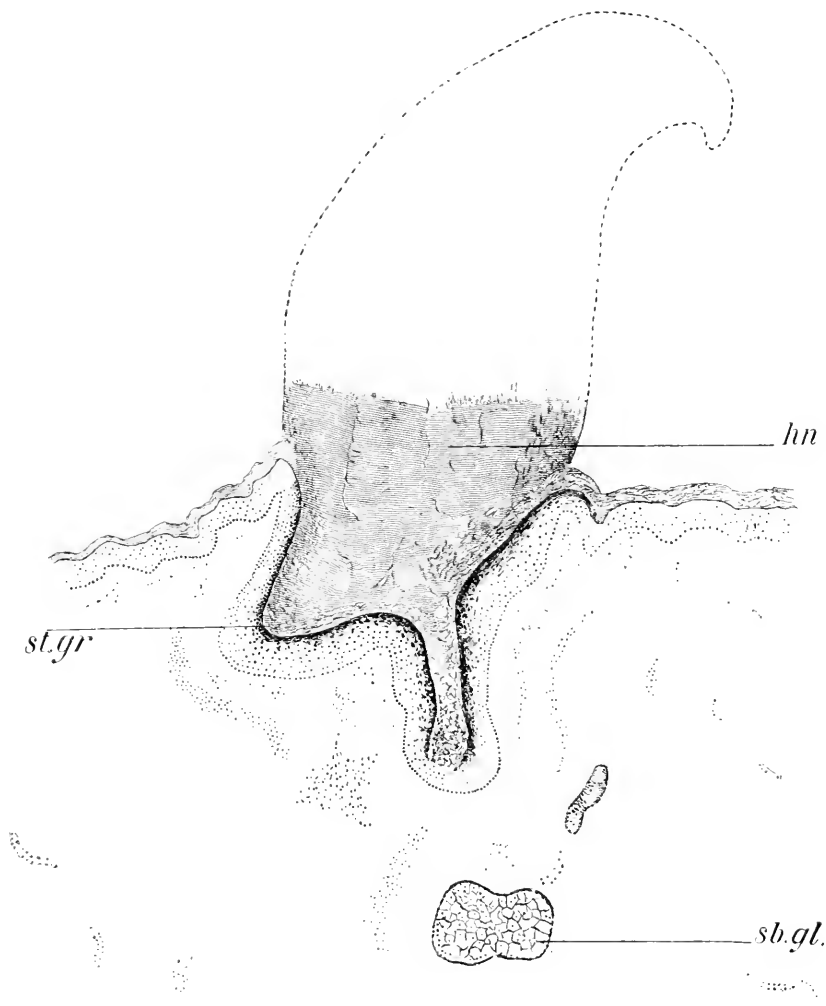


FIG. 1.

Hematoxyline. One per cent. HCl solution. Eosine. *hn*, horn, the upper part represented diagrammatically by the dotted outline; *st. gr.*, stratum granulosum. Kerato-hyaline granules deeply stained by the hematoxyline. *sb. gl.*, sebaceous gland.

the possible implication of a sebaceous gland. The contents, as I have said, were of a purely horny nature, at least so far as the microscope could be relied on to determine this question. No fat-drops or *débris*, so char-

acteristic of comedo, could be detected. Moreover, the sebaceous glands were found in large numbers at the side of and below the lesion, giving one the impression that they had been pushed aside and downward by the keratosis and proliferation of the epithelial lining of the follicles. This view is supported by the histological appearances of the minute lesion from the shoulder, which may be taken as an exponent of the primary process (Fig. 2). Sections through the center of the papule showed that the follicular orifice was dilated and filled with the same horny material that was found in the larger lesions. Below could be seen the duct of a perfectly normal sebaceous gland, and still deeper a hair shaft, obliquely cut. In this papule there was not the slightest evidence of change in the sebaceous gland. The process was a keratosis of the mouth of the follicle. The sweat-glands were normal.

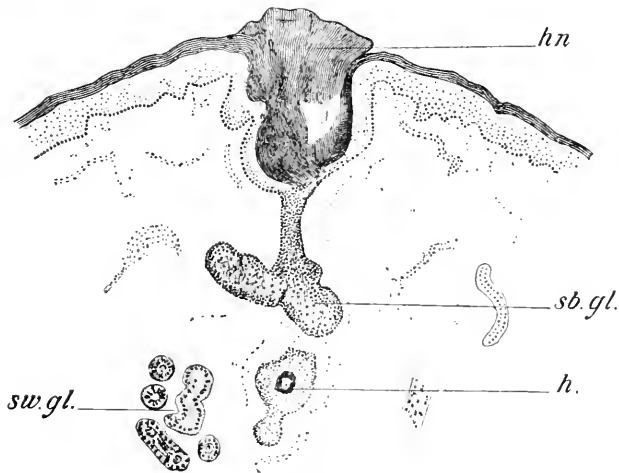


FIG. 2.

*hn*, horny mass in the mouth of a follicle; *sb. gl.*, sebaceous gland; *sw. gl.*, sweat glands; *h.*, hair.

“ Putting together the evidence obtained, the pathological process would seem to be as follows: A keratosis of the epithelial lining of the mouths of the follicles, which, by extension downward, gradually produces the pouch-like depression in the corium represented in Fig. 1. The capacity for corneous metamorphosis is so great that the central portion becomes a firm horn, which, by increasing production of horny matter from below, is gradually pushed out above the surface of the skin. There was no proof that the sebaceous glands were ever affected by the horny change. The three lesions examined would go to show that they are rather pushed down and out of the way by the increasing horny growth in the follicles. On this point, however, the reservation warranted by the small number of lesions examined must be claimed.”

It appears, then, that the process begins, as the gross appearances indicate, by changes in the funnel-shaped mouths of the hair follicles, which are apparently identical with those found in keratosis pilaris. It suggests, too, at this stage, the *cacotrophia folliculorum* of Tilbury Fox.\* The larger discrete lesions, especially those upon the face, strongly resemble Dr. Morrow's description of the appearances in the case reported by him under the title *keratosis follicularis*.† The anatomical changes in the skin in that case, as given by Dr. Robinson, also seem to be of the same general character as found by Dr. Bowen in this case. But in Dr. Morrow's patient, a man twenty-one years of age, the lesions were uniformly papular and comedo-like, and had not progressed beyond such discrete manifestations after a duration of five years. The sebaceous system was also more implicated in the pathological changes than was apparent in this case.

If now we consider the most advanced lesions it presents, the prominent masses of horny concretions occupying large areas of the cutaneous surface, there can be no question that the only recognized dermatosis which presents similar appearances is *ichthyosis hystrix* or *cornea*. Yet the general picture of the disease and the character of the primary lesions do not suggest such a diagnosis. The commonly accepted definition of *ichthyosis* is a disease of the upper layers of the skin, which begins within two or three years after birth, and affects nearly the whole surface uniformly and continuously from the start, although the process becomes more pronounced after childhood, and is always more exaggerated in some parts, while other regions of small extent remain practically exempt. The characteristic phenomena from the beginning are dryness and scalliness over large continuous areas, and the tissue changes are uniform thickening of the epidermal layers with corresponding elongation of the papillae. In this case the first manifestations are papular in character, and separated from each other by considerable interspaces of perfectly healthy skin. It is only by the slow enlargement of these primary lesions, and by their multiplication over such normal intervening spaces, that the whole surface of a given area becomes finally affected. But even then, although exhibiting far greater thickening and prominences than ordinary *ichthyosis*, it is never scaly. The minute anatomical changes, too, are wholly dissimilar. Instead of affecting the cutaneous tissues uniformly at first, they are confined within the openings of the hair and sebaceous follicles, and the surrounding epidermal and papillary layers are entirely normal. It is only by the enlargement of such individual centers that the skin as a whole becomes later involved. From such a typical *ichthyosis* it is evident that this case differs in every important respect.

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\* Clinical Society's "Transactions," vol. xi.

† "Journal of Cut. and Ven. Diseases," September, 1886.

But there is another kind of ichthyosis, so called—a very different and much rarer affection—characterized by the formation of prominent horny concretions of various shapes, styled ichthyosis hystrix, or porcupine disease, and between such lesions and the most advanced manifestations in this case there is great similarity, or, it may be, actual identity. Several authors have called attention to the restriction of the cutaneous changes to the follicles in some forms of ichthyosis. Thus Kaposi states\* that the earliest stage of ichthyosis may be the condition known as lichen pilaris. Lesser† speaks of the resemblance of ichthyosis to lichen pilaris, but holds that it differs from the latter in the greater degree of cornification of the epithelium, and calls it *I. follicularis*. He refers to Guibout's description of the affection under the title *acne sebacea cornea*, which he regards as a misnomer. Behrend‡ describes a special form localized at the openings of the follicles under the name *ichthyosis follicularis*, and considers it to be identical with Fox's *cacotrophia folliculorum*.

These forms, however, all begin early in life, and do not establish by later developments any other ground of identity with the advanced lesions in our patient, or with those of the rare cases on record known as *ichthyosis hystrix*. Nor are exact data available covering the early history and mode of development of the latter, by which we may determine the points of resemblance of our case to them in the early stages. There can be no question, however, as to the intimate relation between them in the most advanced stages of development, both in anatomical features and gross appearances.

It may be, therefore, that this case is only an additional example of true *ichthyosis hystrix*, so called, of which but very few well-known instances are on record, and that the doubt or delay as to accepting such a diagnosis rests upon a want of knowledge on our part of the initial changes which characterize the latter. But if this be possibly the correct diagnosis, it establishes in my mind the conclusion that the title is wrong, and that the process we have been studying can not properly be called an ichthyosis. It is a wholly different affection from ordinary ichthyosis in the location of the primary process, in the character of its individual lesions and entire sequence of appearances from first to last, as well as in the history of its progress. If this indeed be an example of hystricismus, presenting, as it does, opportunity for the study of its anatomical characteristics in every stage of development, it suggests the adoption of the more appropriate names *ichthyosis follicularis* or *keratosis follicularis*.

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\* "Pathol. und Therap. der Hautkrankheiten," p. 515.

† V. Ziemssen's "Handbuch der Hautkrankheiten." Bd. 1, p. 477.

‡ "Lehrbuch der Hautkrankheiten," zweit. Auflage, p. 337.

## SUPRAPUBIC CYSTOTOMY FOR THE REMOVAL OF A CATHETER RETAINED BY AN INCRUSTING STONE.

BY C. B. WOOD, M. D.

THE patient, a Japanese male, aged thirty-two years, was brought to the Queen's Hospital, Honolulu, from the Island of Kauai on February 17, 1889. No reliable history could be obtained from him, but the facts as subsequently given by the physician who first attended him are as follows:

On January 9th, while walking on an elevated rail-track in the Kealia sugar-mill, the man fell astride of one rail, striking on his perinæum. He continued his work until evening, and then complained that he could not pass his urine. There being no physician on the plantation, the plantation chemist (a former hospital steward) attempted to pass a No. 7 catheter. The chemist made several attempts at intervals, and stated that he had drawn off some bloody urine each time. Subsequent events, however, proved that his efforts had only resulted in severe laceration of the already ruptured urethra.

Dr. W., physician to a neighboring district, happening to visit the plantation the next day, was called in, and found the patient in bed suffering intensely from non-evacuation of the bladder. "On examination, found a tumor in the perinæum. Passed a catheter to the seat of rupture and found false passages in the connective tissue. Blood welled up freely through the catheter. Made an incision at seat of rupture (membranous portion of urethra), and passed a silver catheter from the incision into the bladder, evacuating three pints of clear urine." Hæmorrhage was profuse and it was not possible at this time to pass a catheter through the entire urethra. The doctor then withdrew the catheter, applied a compress to the perinæum, and went his way, leaving instructions with the chemist to remove the compress and allow the patient to urinate through the perinæum on the following morning. The compress was removed according to instructions, but the patient could not pass his urine; the doctor was called again the next day. During his unsuccessful attempts to find the urethra through the incision he had made the previous day, hæmorrhage became "dangerously profuse" and he desisted. He then punctured the bladder over the pubes with a small hydrocele trocar and cannula. After evacuating the bladder the cannula was withdrawn.

The next day, with a vesical trocar and cannula, he made another suprapubic puncture, inserted a soft-rubber catheter through the cannula, removed the cannula, and retained the catheter in the bladder, with the intention of leaving it there until the lacerated perinæum had healed sufficiently to allow him to operate upon the urethra.

Instructions were left with the chemist to wash out the bladder with a solution of boric acid and to move the catheter slightly every day. This was probably not done.

About a month later he was sent to the Queen's Hospital, Honolulu, where he arrived, as previously stated, on February 17th, or thirty-nine days after the injury was received.

An examination disclosed the following: A soft red-rubber catheter, size No. 7, projecting from the pelvic cavity, in the median line, close above the pubes. It was firmly fixed—not to the abdominal wall at the point of exit, but at some point inside of the cavity. No urine escaped through the catheter. In the median line of the perinaeum, close back of the scrotum, was a small pouting opening through which the man urinated voluntarily, and with considerable difficulty. To the left of the median line, just back of the perineal opening, was a small tumor about the size of a pigeon's egg. A bougie passed in at the meatus met a solid obstruction about a quarter of an inch in front of the perineal opening.

March 3, 1889. The patient was placed upon the table and anesthetized, and a further unsuccessful attempt made to loosen the catheter. A wire passed into its lumen met with a gritty obstruction.

A bougie passed into the perineal opening was found to run immediately into the small tumor before mentioned in every instance. A grooved director was then passed into the tumor or sac, for such it evidently was, and it was freely laid open and evacuated of about a drachm of pus mixed with urine. After about one hour had been spent in vain attempts to pass sounds, probes, and filiform bougies, a small silver probe was slipped into the bladder. As the probe passed in at the neck of the bladder it came in contact with sabulous or gritty substance. A No. 1 catheter was placed in position and the patient put to bed.

On the day following the introduction of the No. 1 catheter it was replaced by a No. 3, and on the next day by a No. 5.

March 6. Introduced a good-sized silver female catheter and fastened it in place.

Washed out the bladder with a saturated solution of boric acid. The bladder was washed out every day with a boric-acid solution until March 10, 11 A. M., when the patient was again anesthetized. A lithotrite was without difficulty passed into the bladder through the now well-dilated perineal opening. A small foreign body was soon engaged in the jaws of the instrument, which was then screwed down. This was repeated several times, when the catheter (suprapubic) became loosened, and urine began to issue from its mouth and also from around its sides.

It was thought advisable to desist from further efforts at crushing, and the lithotrite was withdrawn. A large (No. 12) soft-rubber catheter was introduced, and the patient put to bed. Little pain and no fever followed

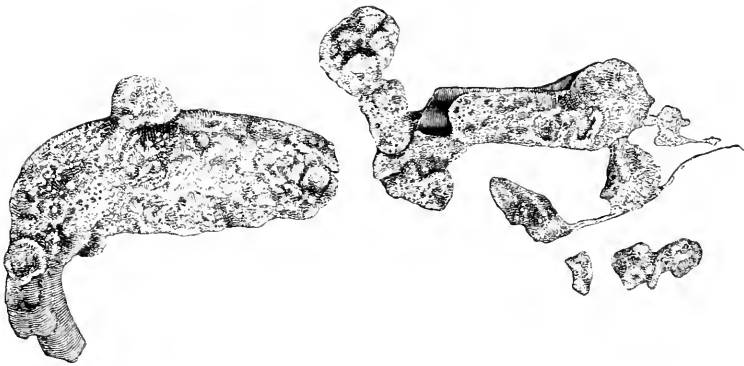
this operation, although pretty free hæmorrhage occurred during the efforts at crushing.

March 13. Upon the advice of Dr. Morrow, of New York, it was now decided to perform suprapubic cystotomy. The patient was placed upon the table and anesthetized.

Present were Dr. Prince A. Morrow, Dr. G. Trousseau, Dr. N. B. Emerson, Dr. R. McKibbin, and the writer.

An incision was made in the median line, extending about two to three inches above and half an inch below the suprapubic catheter.

Considerable difficulty was experienced in reaching the bladder, on account of its collapsed condition. Attempts to dilate it were frustrated by the free exit of the fluid *around the sides* of the suprapubic catheter. A rectal colpeurynter was introduced, and about ten ounces of fluid forced into it. At this stage of the operation the suprapubic catheter broke off inside of the bladder. A steel sound was immediately introduced in its place, entering the bladder without difficulty. A curved bistoury was in-



serted alongside of the sound, and an incision an inch long made into the bladder. The stone was found close in the neck of the bladder, and was removed in several pieces by Dr. Morrow, partly with the finger and partly with a small pair of forceps.

The shape and size of the fragments are indicated in the accompanying illustration. The largest piece measured an inch and a half in length by three eighths of an inch in width.

The bladder incision was not sutured. A No. 12 soft-rubber catheter was inserted into the bladder through the suprapubic incision and another through the perineal opening, and both were retained in place.

Three deep silk sutures were taken through the abdominal incision, and the wound dressed with powdered boric acid.

March 14, A. M., temperature 100.6° Removed perineal catheter and



replaced with fresh one. Washed out bladder with solution of boric acid; p. m., 99·8°.

March 15, A. M., 98·6°; M., 99·8°; P. M., 98·9°.

March 16 and thereafter, temperature normal.

Removed the catheter from the bladder, and inserted a small drainage-tube through the abdominal wall.

The perineal catheter was changed for a fresh one, and the bladder washed out every day until the catheter was removed entirely.

March 20. Removed the stitches. Abdominal wound healed.

March 26. Patient placed on the table. No anæsthetic used. A lithotomy staff was passed into the urethra at the meatus, and carried down to the obstruction in the urethra, a quarter of an inch in front of the perineal opening. A straight bistoury was then inserted in the perineal opening and pushed through to the groove in the staff, and the plug of cicatricial tissue freely incised.

This opened up the entire length of the urethra, and a No. 5 catheter was inserted from the meatus into the bladder. The catheter was fastened in and left for twenty-four hours, when it was changed for a larger one. This process was repeated every twenty-four hours, until on March 31st a No. 12 soft-rubber catheter passed freely into the bladder.

April 2. Removed the catheter altogether.

April 4. Patient voids his own urine without any difficulty, a small quantity escaping through the perinæum.

April 10. The patient is in excellent general health. A small amount of urine still escapes by the perinæum, but much less than at first.

HONOLULU, April 10, 1889.

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## NON-PRURITIC LICHEN PLANUS FOLLOWING AMPUTATION.

By CHARLES P. RUSSELL, M. D.,  
Utica, N. Y.

THE following very interesting case I saw July 15, 1888, through the courtesy of Dr. George A. Krug, of this city. The patient gave the following history: M. N. B., male, forty-four years of age; American; night-watchman by occupation, and married. He is a tall, well-developed man, with light hair and fair complexion. His present general health is excellent; never had any form of skin disease prior to the one now to be described. He gives no history of syphilis, and a careful examination reveals no traces of the disease. In the summer of 1883 he had the fingers of the right hand crushed by machinery, necessitating partial amputation of all four, as shown in the cut. The present eruption began to make its appearance, about one month after the opera-

tion, upon the flexor surface of the right wrist, the one corresponding to the injury. He first observed a number of pin-head-sized, round, hard, pinkish papules. They were clustered together in a group. Others soon began to appear upon the flexor surface of the arm and forearm, all pre-



sented the same characteristics as those upon the wrist. There was no pruritus.

In about six months from the time they appeared upon the right wrist and arm, the flexor surfaces of the left forearm and wrist became the seat

of a number of papules. They were discrete hard lesions of a dusky red color and non-pruritic. The manner of their distribution was almost exactly similar to that on the right. Near the end of the first year the disease began to crop out upon the back in the lower dorsal and lumbar regions, extending about an equal distance upon either side of the spine. At varying times within the last four years scattered papules have developed upon the thighs, abdomen, chest, and shoulders; but they are comparatively scanty in these situations. There is, however, quite a distinct group in the center of the chest over the gladiolus. According to the patient's description (and he seems to be an intelligent and observing man), the papules were uniformly about the size of pin-heads when first observed. They then gradually enlarged until many of them attained the size of split peas. As they grew larger they assumed a deeper red tint, became flattened, and took on a slightly angular outline. The present condition of the eruption, at the expiration of now five years of existence, is substantially as described. The disease has invaded no new territory during the last three years and a half. As said before, there has never been marked pruritus, the nearest approach to a paræsthesia being a slight burning sensation in the papules on the back when he is warm in bed. The lesions at present vary in size between a pin-head and a split pea. Many of them, especially those upon the wrists, forearms, and back, where they are grouped, show depressed centers and slight scaling. The color varies in different situations from an ordinary red to a violaceous tint. Scattered in here and there among the fully matured papules may be seen small, irregularly shaped pigment-stains, evidently the sites of former lesions. This pigmentation is of a muddy, light-yellow tint, resembling the color of some of the outlying spots near the periphery of a tinea versicolor patch. A peculiarity of these maculæ is that the surfaces have a slightly shriveled look when viewed under oblique light.

It seems to me that this case presents some unusual and interesting features. In a case of lichen planus existing five years we would expect more or less pruritus at times. The papules in this case have never itched. They have never coalesced to form actual patches, as they are prone to do in long-standing cases of this affection. Upon the back, wrist, and in places upon the forearm, they show the grouping characteristic of lichen planus; but even in these situations there is an appreciable interval of healthy skin between them. The case here presented derives its chief interest, as it seems to me, from the ætiological side. What influence, if any, had traumatism in its causation through long-continued reflex action upon vaso-motor nerves? That the eruption might have been due to reflex nervous causes seems to me reasonable to believe. We know that injuries to trunk nerves are sometimes followed by tropho-neurotic changes in the integumental area supplied by the injured nerve,

as many reported cases show. Dr. Stephen Mackenzie, of London, reported to the Harveian Society in 1885 a case of lichen planus in which the papules were arranged around one half the back and abdomen in band-like form like zoster, the eruption at a later period becoming generalized. Also, a second case in a very nervous woman, in which the lesions occupied a tract corresponding to the internal cutaneous and ulnar nerves of one arm. An eruption of acute generalized lichen planus has been known to follow immediately after severe nervous shock. Dr. Malcolm Morris reported such a case at a meeting of the Harveian Society (see *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES*, vol. iii, p. 123). Other cases might be quoted bearing on this subject and tending to prove that lichen planus may sometimes be of nervous origin. It would seem reasonable to refer localized unilateral eruptions to local lesions of the nervous centers. Now, the first of Mackenzie's cases here quoted shows that a localized neurotic eruption may after a certain period become generalized and symmetrical, which fact goes far to prove that a general disturbance of the central nervous system capable of evoking a symmetrical eruption may be based upon or grow out of a localized lesion of the spinal centers. In the case here recorded, as a reference to the history will show, the eruption remained for six months localized to the anterior surface of the arm corresponding to the injury. It then rapidly invaded the other arm, and became symmetrical in arrangement in all other portions of the body involved.

The manner of development in this case is certainly suggestive of a neurotic factor in its production, and I therefore place it upon record as a contribution to the aetiology of this interesting affection.

198 GENESEE STREET.

(NOTE.—A case of well-marked lichen planus of six months' duration, in a woman aged forty years, is now under Dr. Bronson's care in the New York Polyclinic. The eruption is present on the hands and forearms in the form of the characteristic papules; on the legs large scaling patches exceeding in size a silver dollar are seen. The patient states that she has experienced no itching during the course of the disease.—ED.)

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 189TH REGULAR MEETING.

DR. E. L. KEYES, *President, in the Chair.*

**Paget's Disease of the Nipples.**—DR. LEWIS presented a woman, thirty-five years of age, married, and the mother of two children. Two and a half

years ago, while nursing her first child, the right nipple became diseased, and not long after the left one also. He first saw the case in September, 1888, and found both nipples and their areolas covered with small crusts, which were easily removed, exposing a raw and moist surface. The skin was thickened, and both nipples were larger than normal. Burning pain and itching were constant and annoying. The mammary glands seemed normal and there was no disease in the axillæ. No history of cancer. The persistence of the disease as well as the general appearances were suggestive of Paget's disease, and its course has been carefully observed. During the past four weeks, under a salicylic-acid and oxide-of-zinc ointment, considerable improvement had occurred. The case was presented for the opinion of the members of the society as to whether Mr. Lawson's opinion—"that the breast should be amputated if the eczema resists ordinary treatment for a year"—should be followed in this instance.

DR. BRONSON, in discussing the case, stated that he thought there was only eczema present. The diffuseness of the eruption was not characteristic of Paget's disease, but of eczema. Besides, it was symmetrical, there was no induration beneath, and the patient was of an age when carcinoma does not often begin.

DR. KEYES asked whether a limit of time had ever been established when the eczematous symptoms became malignant in character. The general opinion seemed to show that such a limit had not been established, but that the symptoms persisted a long time before they became malignant.

DR. KLOTZ, DR. ALLEN, and DR. JACKSON did not think it was Paget's disease, but eczema, and an operation at present was not justifiable.

DR. SHERWELL thought that the affection being double was peculiar. He would advise trying to cure the eczema in the present case. He would refer to a case he had presented in 1881. There was no danger of waiting in Paget's disease, and the latter was more easily eradicated than a scirrhus would be.

DR. BULKLEY said that if it was Paget's disease there would be a retraction of the nipple. In this case the nipples were enlarged as by an inflammatory process. In Paget's disease the color likewise was not so red. The case was purely one of eczema in a nursing woman, very difficult to cure, but perfectly safe to be left without operation.

DR. FOX stated that many cases of eczema of the nipples persisted for many years without becoming Paget's disease. Moreover, this latter could develop without a preceding eczema. In Dr. Lewis's case the involvement of both nipples would speak for eczema.

DR. TAYLOR agreed with Dr. Bulkley and Dr. Fox. The possibility of epithelioma developing attached more apprehension to an eczema of the nipple than was really necessary. Some cases of Paget's disease were preceded for years by a raw and oozing surface; others developed without such symptoms.

DR. KEYES was in accord with the remarks already made. Paget's disease began sometimes *de novo*, sometimes after a previous eczema of the nipple. The patient presented to-night was very anæmic and run down, and those factors would bear directly upon the persistence of the eczema. The

safety of the patient lay in Dr. Lewis's taking hold of the first sign of malignant degeneration.

DR. LEWIS did not himself think that the nipples were already cancerous. An important point was whether such a persistent eczema was not dangerous and might not lead to Paget's disease when the patient became thirty-eight or forty years of age. Paget had reported fifteen cases, some of which were moist and red, some dry and scaly. In his opinion, they began at first as simple eczema. He had had two cases in the last two years. One of them had very little eczema on both the nipples which had been observed a year and a half. The lactiferous ducts of one mamma then became hardened and painful, and after removal of the gland it was found to be entirely cancerous. On the other nipple the eczema persisted; there had been no retraction of the nipple. In his second case a tumor developed in the breast. Both cases had presented similar symptoms to the one shown to-night, one double and the other single.

In answer to the question of the treatment employed, DR. LEWIS stated that he had applied iodoform collodion and salicylic ointment, and tonics internally.

DR. KLOTZ recommended gelatin, which he had found especially useful in cases of eczema of the nipples.

**Case for Diagnosis.**—DR. JACKSON presented Kate M., married. Up to last December she had never had any trouble with her skin. She then had an outbreak of an eruption consisting of redness, vesicles, and blisters, attended with a great deal of itching and constitutional disturbance. It involved pretty much the whole surface of the skin. It was pronounced an eczema by her physician. After three or four months of sickness she recovered her health, but soon again began to have trouble with her hands. He saw her for the first time some three weeks ago, when, though she complained a great deal of itching of the hands, there was not much to be seen except what appeared to be a superficial dermatitis. She was given tonic remedies. Blisters came out on her hands, so that when I saw her last she had several bullæ between the fingers of both hands, a large number of papules subcutaneous on both palms, bullæ and vesicles on the backs of the hands, and grouped papules upon the wrists. He also called attention to the marked pigmentation of her arms and neck and legs left by the previous eruption in the early part of the year.

DR. BRONSON regarded the case as one of dermatitis herpetiformis.

DR. KLOTZ thought that the same symptoms could be found in eczema. He would not make the diagnosis of dermatitis herpetiformis.

DR. SHERWELL would prefer calling it dysidrosis, as the appearances between the fingers suggested the lesions of this disease.

DR. BULKLEY said that he saw the patient in December, 1888, and then thought the eruption was eczema. There was a great deal of eruption on the body and the arms. He then saw the case again in January, 1889, and changed his diagnosis to dermatitis herpetiformis. She was then six months pregnant. After having a miscarriage, the eruption disappeared, and has returned in an entirely different form—the present one. Some cases of dermatitis herpetiformis were eczematous in character.

DR. FOX did not think it was eczema, nor was it dysidrosis. It was, how-

ever, a neurotic grouped vesicular eruption. He thought hydroa would be a better term for it.

DR. ROBINSON said that he might suspect it to be dermatitis herpetiformis, but still would not make that diagnosis. It certainly was not dysidrosis.

DR. TAYLOR could not see any resemblance of the eruption to dysidrosis. He did not think it was eczema, but would not make any diagnosis.

**Xanthoma Diabeticorum.**—DR. ROBINSON presented a case of this disease affecting an engineer, aged thirty-one, who had always enjoyed good health and a good appetite, and had never suffered from jaundice. The eruption first appeared on the buttocks about three months ago. At present there were probably between a thousand and fifteen hundred tumors on the body. The lesions varied in size from a pin-head to a large pea, were firm, elevated, and seated in the corium. The small lesions were conical or pointed, slightly reddish in color from capillary hyperæmia. The redness disappeared almost entirely upon pressure, and the tumor then was yellowish in the central part, with slight redness in the peripheral portion. The larger lesions were elevated, obtuse or flat, smooth or uneven on the surface, the furrows corresponding to the blood-vessel situation. As in the smaller lesions, the yellow color in many was not very distinct until the redness was removed by pressure, but in the majority all but the peripheral part was yellowish in color except where crossed by blood-vessels. Many of the largest lesions seemed to be made up of several isolated yellow areas separated by hyperæmic tissue. None of the tumors were of the flat form of xanthoma, and all were very firm in consistency. An occasional tumor had an irregular or oval form, but all were more or less round. The majority of the lesions began to develop around the hair follicle. Itching was at times marked, but at others only slight. The tumors were located principally over the gluteal and lumbar regions, where there were several hundred, on the extensor surfaces of the forearms, on the anterior surfaces of the legs, and on the calves. The face was free with the exception of a single pin-head-sized tumor just forming on the left side of the nose on a level with the eye. There were many scattered lesions over the trunk and limbs. The palms and the soles and the mucous membranes were free. Examination of the urine showed a very large quantity of sugar. Beyond this the internal organs were normal. The case was at first presented as one of fibroma cutis.

DR. BULKLEY, in the discussion, said that he thought xanthoma should be considered. He had a model which resembled Dr. Robinson's case exactly, and he would suggest that the microscopical examination of the excised pieces be completed and the patient be then presented at another meeting.

DR. SHERWELL thought the affection would be found to be xanthoma, and believed that it would develop around the eyes later. He had under his care a case entirely similar in localization. He would consider the lesions as xanthoma and not fibroma.

DR. ALLEN thought the case to be one of xanthoma, and was also of the opinion that diabetes would be found present. The patient had told him that he suffered from thirst, and urinated a great deal. Besides, he had described to him a white spot left on the trousers by the evaporation of the urine, which Dr. Allen had always observed as occurring in diabetic patients.

DR. ROBINSON, in closing the discussion, said that he had thought of fibroma and xanthoma, but was not satisfied of its being xanthoma, owing to the number of lesions which were not yellow. Fibromata were sometimes of a yellow color, caused by the implication of the sebaceous glands. The growths, as far as he had already examined them microscopically, seemed to originate from the hair-follicle sheath, and that also was a point in favor of fibroma. Still, until he had further studied the case, he would not make a positive diagnosis. (Since making these remarks, Dr. Robinson has decided that the case was one of xanthoma diabeticorum, under which name it is now reported.)

**Eczema Seborrhoicum.**—DR. ROBINSON presented a female who had suffered from the eruption for ten years. There were a great number of spots, varying in size from a bean to two and three inches in diameter, which were sharply limited and covered with fine scales. They were situated over the trunk and the scalp, occupying the typical localization of seborrhoic eczema. It was peculiar that the lesions had not coalesced, notwithstanding the long duration of the eruption. The patient had been treated with a three-per-cent. resorcin ointment and with sulphur without benefit. Rapid improvement, however, under white precipitate ointment, bismuth, and oxide of zinc.

DR. KLOTZ thought it was strange that there were no larger patches, no involution of the process in the central portions, and that the spots were so uniform in size.

DR. BRONSON said that the case did not agree exactly with his idea of seborrhoic eczema. If it was a case of that affection, Dr. Robinson ought to make a careful microscopic examination of the skin.

DR. ROBINSON stated that under the microscope the appearances were not like psoriasis in any way. Clinically, in psoriasis he would expect to find clearing in the center. The small brownish scales occurring here were not seen in psoriasis. Still, he would call attention to the benefit derived from hydrarg. ammoniat. when resorcin and sulphur had failed.

**Persistent Erythema.**—Presented by DR. G. H. FOX. According to the statement of patient's physician, syphilis had been contracted by the former in the fall of 1886, although there was no remembrance of an initial lesion. Dr. Fox first saw him in September, 1887. He then had dusky-red patches on the trunk and the extremities which appeared to be a relapsing erythematous syphilide. He was seen again in December, 1888, when it was found that the trunk and extremities were covered with an erythematous eruption occurring in indistinct patches of variable size. No itching or burning except after taking medicine. Arsenic had caused the spots to become redder and slightly scaly. Mercury had caused the spots to fade, but produced diarrhoea. Treatment by strict dieting had failed to have any effect upon the eruption. It seemed now that the eruption had nothing to do with syphilitic infection.

DR. BULKLEY regarded it as a peculiar case. He thought it would disappear under the use of ergot. In a case of persistent erythema which he had had, large doses of ergot, 3 j twice or three times daily, had greatly improved it.

DR. BRONSON thought that the name erythema was not applicable. Ery-



thema means inflammation with hyperæmia and exudation. This was not the case here. He considered it to be a vaso-motor disturbance.

DR. KEYES asked why the diagnosis of syphilis had been made.

DR. FOX said that he supposed it was on account of the eruption. There was no history. The eruption looked like a relapsing erythematous syphilide, and he had thought so at first; but, on seeing the appearances a year later, he had changed his mind and thought that it might be from some ingested drug. Such had not, however, proved to be the case.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**Weekly Conferences at the St. Louis Hospital.**—During the past four months the physicians of the St. Louis Hospital in Paris, wishing to better utilize the great mass of dermatological material at their disposal, have established a weekly reunion for each Thursday morning, at which they present the interesting cases of their respective services and of the external polyclinic. These conferences will without doubt give a new impulse to the study of skin diseases in France. Unfortunately, though they are to be of incontestable utility to the dermatologist already accustomed to the difficulties of the question, they will not have any practical worth for the profession at large and will be of little interest to the great medical public. It is especially the isolated, peculiar, and very rare instances of dermatoses which will be studied, and the matter of treatment is almost always left in obscurity. If desirable, a full report of the proceedings may be read in the reports which appear in the "*Annales de dermatologie et de syphiligraphie*." To-day I will refer only to a few communications which appear to me the most important from a practical point of view.

**Generalized Favus; Cicatrices following Favus upon the Lower Extremities.**—Dr. Hallopeau showed on December 6, 1888, a patient affected with favus who had rounded cicatrices upon the legs, slightly depressed and pigmented about the borders, occurring in circles, and having the aspect of syphilitic cicatrices. They were evidently due to favus corporis, for there were to be seen upon the patient's body in the location of the scars, or near them, plainly marked and characteristic favus cups. Furthermore, the patient had favus of the scalp and of the nails. Iodized vaseline appeared to act well in the treatment of this case. Dr. Besnier regarded the case as altogether exceptional. In the many cases of favus corporis which he had seen, he had never before found cicatrices. Dr. Lailler commented upon the long persistence of the favus germ in the same individual and its vitality. He cited the case of a man who, having had favus in his infancy, suffered from a recurrence upon simply becoming debilitated and without being exposed to a new contagion. He had also observed the following case of contagion: A woman having favus remained for a certain time in his service. Upon her

discharge, the bedding was not sufficiently disinfected. Two or three months later, the patient who succeeded her in occupying the bed became affected.

**Chronic Erythema Nodosum of the Lower Extremities.**—Dr. Besnier presented (November 29, 1888) a young woman having aphlegmasic nodes upon both legs which spring from the hypoderm and secondarily affect the superficial layers of the skin which assume a livid tint. The nodosities do not ulcerate unless accidentally injured by external violence, and there is no tendency to spontaneous suppuration. They resemble very closely syphilitic gummata or scrofulo-tubercular lesions, but differ from them in their immobility, their prolonged duration, and in the fact of their not softening. They differ from erythema nodosum of the common variety by their exclusive localization upon the limbs, their development about its whole periphery, by their long persistence, and their indolence. The iodide of potassium has no action upon this disease, which gets well after repose in the horizontal position and compression. It often coincides with pain in the legs, doughy edema of the hypertrophying form in young girls with irregular menstruation, whose occupation requires them to stand much of the time. As treatment, baths for the legs, containing eucalyptus leaves, and massage are recommended.

On January 17, 1889, Dr. Feulard presented a young laundress who had been overworked, and who for the past year had suffered from hard nodosities of both legs of an erysipelatous redness which formed veritable tumors. According to him, it is a form of indurated erythema peculiar to young girls, and this condition should evidently be closely allied to Besnier's chronic erythema nodosum. Professor Fournier observed that, from an objective point of view, the lesions are altogether identical with the syphilitic gummata of the spread-out or flat variety.

**Paget's Disease.**—Dr. Hallopeau (January 31, 1889) presented two patients who have been attacked for the past seven and eight years, respectively, with the disease of the nipple called by the name of Paget. Wax casts which had been taken of the condition in its previous stages permitted the whole history of the cases to be taken in at a glance. He spoke of the localization at the summit of the breast, the slow extension, the very bright-red color, the clearly marked external limits, the retraction of the nipple, and finally on the ultimate invasion of the mammary gland. He believes it to be an epithelioma of an altogether special form. Dr. Vidal had had three cases. He thinks the affection has nothing in common with eczema, although it is eczematiform. His histological examinations have shown him that there occurs a marked proliferation of epithelial cells toward the galactiferous ducts, and all about them a proliferation of fibrous tissue, which explains the retraction of the nipple. He, too, believes it to be a special form of epithelioma. In the beginning it can be treated by scraping and application of powdered chlorate of potash, just as in superficial epithelioma. Besnier had seen a large number of these cases in his private practice. The first sign of the beginning affection is, according to him, a horny crusting over of the apex of the breast. When Paget's disease is already well advanced on one side, this crusting often exists on the opposite side. He believes there are several forms of Paget's disease: First, cases in which there is induration and retraction of the breast;

these cases are severe, and operation should be undertaken at once by ablation of the diseased part and the whole of the gland. Second, cases in which there is no induration or retraction of the nipple, and in which immediate intervention is not necessary. Dr. Quinquaud insists on the importance of the diagnostic point of superficial parchment (papyrané) induration of the affected parts.

**Dermatosis of the Palm of Difficult Diagnosis.**—Dr. Besnier (December 27, 1888) presented a woman, forty-two years of age, affected for eight years with a peculiar condition of the right palm. Two years after it began the left hand became affected. Since then, despite periods of great amelioration, complete cure has not taken place. The affection appears to be subject to successive periods of exacerbation and calm. Upon the anterior surface of the left wrist is found a plate formed by the union of rounded lesions, each about a centimetre in diameter, of a coppery-red color, projecting slightly above the surface, and having well-defined margins. Some of these lesions are covered with a thick scale or membrane, which comes off in a single piece, leaving exposed a red and bleeding surface. At certain points fissures are seen. The whole palmar surface is somewhat deformed and as though hollowed out. In the outer half the lesion is characterized by redness, a glossy appearance, and a dry and harsh condition of the skin. This zone is limited by a border, which follows the metacarpal bone of the thumb. Upon the inner side the limit is less distinct, and some plates invade the dorsal surface of the fifth metacarpal. At the base of the second and third fingers hard, horny elevations are found, and the whole hypothenar eminence is covered by these elevations. The lesions are almost identical upon the right side. The nail of the left thumb is somewhat elevated by a mass of horny material. The soles of the feet are spared. In discussing the case, Dr. Besnier rejects successively the diagnosis of horny eczema, because the lesions are too circinate and have always been free from exudation; of syphilis palmaris, because there is not sufficient infiltration, and, further, because there are fissures and the course has been too long; of lupus erythematosus of the extremities, of symmetrical keratoderma, because there are no lesions on the feet, and because of the eruption upon the wrists. He adopts the diagnosis of atypical psoriasis. Dr. Hallopeau believes it to be a palmar syphilide. Dr. Lailler is disposed to agree with this view, but thinks we must wait until the results of antisyphilitic treatment have been noted. Fournier does not think that we have here either a psoriasis or a syphilis. He has already seen quite a number of such cases, and antisyphilitic treatment has always failed. He thinks the condition a dermatosis of unknown nature, and refuses, for his part, to force the list of classical diseases to admit such isolated cases as this one.

Dr. Lassar, of Berlin, who was present at the discussion, believes that in such cases we have to deal with a mixed result of syphilis upon some dermatosis, psoriasis in particular, and claims to have had good results in submitting patients at the same time to a general treatment for syphilis and a local treatment for psoriasis.

**Margined Exfoliative Glossitis.**—Dr. Besnier (February 7, 1889) presented a non-syphilitic patient, aged twenty-nine years, who had been affected for

four months with an exfoliation of the tongue, characterized by whitish circles somewhat salient, in the center of which the mucous membrane of the tongue is of a red color, smooth, without papular elevations. These circinations are wandering and sometimes change their location quite rapidly, so that the aspect of the tongue is quite changed within a few days. These lesions were formerly looked upon as manifestations of syphilis. Since the work of Parrot, who erroneously considered them as evidences of hereditary syphilis, they have been well described by numerous authors, and in particular by Semounier, under the name of *glossite exfoliatrice marginée*. Dr. Besnier thinks that, from the nature of this affection, it should be considered as a circinate eczema of the tongue. He has seen it frequently coincide with seborrhœal eczema of the scalp or sternum. To cause its disappearance it is necessary, first of all, to study the general condition of the patient and rectify any existing disorders. As regards local care, he recommends emollient mouth-washes, frequently repeated, of hot water, containing boric acid and one or two grammes of bicarbonate of soda to the quart.

**Symmetrical Lichen Pilaris of the Face.**—Dr. Brocq presented (February 21, 1889) a little girl, ten years of age, who has had developing by degrees upon the face since the age of three or four years an eruption which is now characterized as follows: Upon the forehead are the two principal patches, symmetrically situated above the internal portion of the brows. The eruptive elements are so abundant at these two points that they touch each other and form a sort of red patch, upon which, however, are to be seen, when closely examined, quite small projections of the size of the head of a fine needle. These projections become especially apparent when the skin is stretched, and the redness thus caused to disappear from the plaques. This redness is not very pronounced, but it becomes exaggerated upon the slightest rubbing. Between these two plaques, over nearly the whole forehead between the two brows, are seen here and there disseminated the initial lesions of the disease. They are constituted by quite small acuminate projections, which may, however, be rounded at their summit; not colored; have usually a lanugo hair in the center, but in some instances it has been impossible to discover them. They never take on an extensive development. They are seen to begin under the form of minute white points, somewhat brilliant at the summit, slightly prominent, and non-scaly. They become somewhat more voluminous, and new ones are formed in their neighborhood, so that they finally become grouped and the separate lesions touch each other, and from this time on they are surrounded by a little redness. Upon the lateral regions of the cheeks the little prominences of which we have spoken are found quite numerous, closely packed together, forming two large symmetrical plates, which occupy the whole lateral surface of the cheeks; but there is here developed, in addition, a very fine and delicate vascular telangiectasic condition. This new redness, of which the frontal plaques are undoubtedly the first phase, is especially marked at about eight millimetres in front of the ear. At this point the small acuminate projections are much less marked than toward the anterior parts of the cheeks, where they attain in regions relatively large dimensions, and even seem to become somewhat of the nature of acne. Some of these disseminated projections pass the border of the jaw

and impinge upon the neck. Some are equally found upon the free border of the ear. Upon the scalp seborrhœa is found, and a lichen pilaris well marked upon the arms and legs. Internal treatment has consisted in the administration of arseniate of soda, in the dose of from four to eight milligrammes per day, and during the winter cod-liver oil in daily quantity of four soup-spoonfuls. As external treatment, after having tried various means—such as the application of compresses wet in a thirty-per-cent. solution of the hydrochlorate of ammonia, Vigo plaster, cod-liver-oil plaster, salicylic acid, etc.—I adopted the following course, which has been followed by great improvement: Upon the face I make applications of soft-potash-soap plaster, which is omitted as soon as the skin shows signs of irritation. Then some calming pomade is applied, followed by an ointment containing a gramme of tartaric acid and a gramme of salicylic acid in thirty grammes of glycerole of starch. I have had three other patients affected with the same disease, and these have permitted me to study it in the different periods of evolution. The condition has already been described by Erasmus Wilson in his lectures on dermatology in 1878, under the name of *folliculitis rubra*. Dr. Besnier and Dr. Doyon have said a word about it in their notes to their translation of Kaposi's lectures (t. ii, p. 100, note 2), and call it *Xeroderma pilaris*. According to our views, this disease is essentially characterized, first, by its *début* in infancy and by its slow development, which is almost unnoticeable; second, by its very special localization—brows and frontal region above the brows—where it seems at times to be accompanied by a certain thinning of the hairs; lateral surfaces of the cheeks and neighboring parts; region between the brows and upper part of the chin; it is absolutely symmetrical; third, by a lichenoid initial lesion of minute miliary size, little or no desquamation, most always pierced by a lanugo hair, and which is at first without color and isolated, tending to form groups by the multiplication of the lesions, but have but little tendency to augment in volume; fourth, by a vascular element, at first purely erythematous, which appears as soon as the lichenoid elements are multiple, and which may then at times become the preponderant lesion, and be complicated with a certain tumefaction of the integuments. Upon the lateral regions of the cheeks there develop quite rapidly these telangiectases which give a certain violaceous tint to the affected regions. The localization about the brows may exist alone, be little marked, and, so to speak, in a rudimentary condition, characterized by a little redness, a few lichenoid elements of minute size, and a certain thinning of the eyebrows. Under these circumstances, it is but the vestige of the dermatosis of which I speak. I have seen it in this state accompany an erythematous lupus.

DR. L. BROCC.

PARIS, March 31, 1889.

#### THE ORGANIZATION OF INSTRUCTION IN DERMATOLOGY AND SYPHILIS IN GREAT BRITAIN.

DEAR MR. EDITOR: You have done me the honor to ask for publication in your journal a *résumé* of my notes taken on a trip to England, and I hasten to respond to your request with the greater pleasure because of my deep regard for your countrymen. On the 20th of September, 1888, I was appointed by the Minister of Public Instruction to undertake a scientific

mission, having for its object the study of methods of instruction in dermatology and syphilis in England—such a study as Professor Leloid so ably prosecuted last year in Germany and Austria. I remained three months in Great Britain, and was everywhere received with the most flattering courtesy and aided in my difficult task in the most amiable and gracious manner by the English dermatologists. I found a surprising diversity of methods of instruction in the various institutions, but there was everywhere apparent a general spirit of analogy in method. As syphilis is separated as much as possible from skin diseases in the instruction given, I will pursue the same course in this communication.

**Dermatology in London.**—Here naturally are to be found the most numerous official centers for study, and I will give a list of the eleven hospital schools with the chief-of-service of each, beginning with the largest institutions:

*London Hospital.*—Stephen Mackenzie. *St. Bartholomew's Hospital.*—Cripps. *Guy's Hospital.*—Perry. *St. Thomas's Hospital.*—Anderson. *St. George's Hospital.*—Cavafy. *Middlesex Hospital.*—Pringle. *St. Mary's Hospital.*—Malcomb Morris. *University College Hospital.*—Radeliffe Crocker. *Westminster Hospital.*—Colcott Fox. *Charing Cross Hospital.*—Sangster. *King's College Hospital.*—Duffin.

Besides these we find Payne at the Blackfriars, who is also full physician at St. Thomas's, and Warren Fay, who is full physician at the London Hospital; finally, Cottle, Liveing, and Jonathan Hutchinson have recently retired from hospital work. Blackfriars, specially set apart for skin diseases, and where the work is wholly of the nature of out-door consultations, has no regular course of instruction and no students. A large number of cases are treated each day, and the reputation of the attending physicians makes it an attractive place for those wishing to acquire a deep knowledge of this special branch. Here Jonathan Hutchinson presided for many years and added much to the hospital's reputation, and has left there a fine collection of plates.

**Organization of the Official Services.**—As a general thing, external consultations form the important feature. Thus once a week or, as at St. Mary's, twice a week, but never oftener, the chief-of-service meets fifteen or twenty students in the consultation-room, and patients numbering from fifty to a hundred pass in review before him. The London and Middlesex Hospitals have the greatest number of patients. Each patient is carefully examined, and here and there one is chosen for a short clinical demonstration. This service occupies from two to three hours, after which the few cases in the wards are visited.

**The Material used for Instruction,** as we have seen, is very large. We can estimate the number of patients at these institutions for one week at two thousand without counting those at Blackfriars. But London is a large city, and skin diseases are relatively frequent. This material, great as it is, we believe is not made the most of. Each physician for his own part is an excellent professor, and I was struck with the energy and activity with which such dermatologists as, for example, Malcomb Morris strive to interest the students and lead them step by step into a deep and profitable study of the cases.

A chief-of-service who is not a *teacher* is unheard of; all give instruction, and most of them do it extremely well. The defects in making the best use of this magnificent field for study are twofold:

1. The absence of hospital beds.
2. The lack of centralization.

Four, five, or at most six, beds are given up to skin cases in the various hospital services, and these few do not actually belong to the service. At St. Mary's six or eight beds are officially consecrated to dermatological cases. Thus interesting cases can not be followed from day to day, but only seen at intervals; and the system has other obvious disadvantages, such as inability to watch treatment and examine the patient's whole body stripped of clothes. The second defect, consisting in the widely separated services of London, is a very grave one. Patients go to the British Hospital, the St. John's Hospital, or other institutions, guided by an idea of speculation, and are lost to science, while a central hospital for diseases of the skin would soon acquire a reputation which would bring them together as in Paris and Vienna.

**Comparative Calculation.**—In Vienna, a city of over a million inhabitants, 150 skin patients present themselves daily at the hospital, or one patient to 5,500 inhabitants. In Paris 300 patients are seen each day at the St. Louis, or a proportion of 1 to 8,000. In London, with its eleven centers for dermatology, to which Blackfriars may be added, we find about 330 patients treated daily, which would give a proportion to its inhabitants of only 1 to 16,000. Two hundred patients are thus daily lost to science by this want of centralization. The attending physicians have not the same facility of communication with each other as where their services are side by side, and museums, collections, special libraries, and laboratories are not so apt to be founded as when the forces are united. It is to be hoped that the London dermatologists may be able to solve the problem for themselves.

The manner of choosing a chief to fill a vacancy in these services differs from that in vogue in France. It is the man whose work in dermatology had specially fitted him for the position who usually obtains it. The English surgeon succeeds to this position of distinction at an earlier age than his *confrère* in France. I am aware that it is necessary for a specialist in dermatology to have an excellent general knowledge of medicine, and possibly in England one becomes a specialist somewhat too early; however, there is no excess in this direction, but I should judge rather an excess on the opposite side in France, where it is scarcely possible to secure any position before the age of thirty-five, and that after devoting all one's forces to general medicine, often at the expense of dermatological knowledge.

**Dermatology in Ireland, Scotland, and the Provinces.**—We can not hope to find here a very complex dermatological organization. Large cities are necessary for a specialty. Everywhere that we have been the material has appeared insufficient, and if dermatology is held in high esteem it is due to the excellence of the teacher. In London the dermatologist does admirably with what facilities he has, but this compliment is here much more merited.

We find professors of very great reputation, authors of classical works of great worth in these smaller cities, but dermatology has no official organization, and the specialty has been created in these countries by the men them-

selves. MacCall Anderson has a special service of his own with twenty beds, the only service of the kind in Great Britain. Among other well-known names are Jamieson, of Edinburgh; Walt. G. Smith, Finny, and Wallace Beatty, of Dublin; Brooke, of Manchester; Simon, of Birmingham; and Waldo, of Bristol.

**Syphilis in Great Britain.**—Teaching in this branch is not sufficiently organized. The chiefs of surgical services take advantage of every opportunity to give such instruction as they can, and occasionally a regular course is given. Berkely Hill gave one in 1888, but there are no special consultations for the purpose of teaching venereal diseases.

At St. Thomas's there are eight beds for such cases—two to each surgical service—but they were never all occupied at our visits. The only real venereal service in Great Britain is at Edinburgh, and has forty beds. The senior assistant surgeon holds the position of chief until appointed full surgeon. Dunlop, a distinguished surgeon of Glasgow, has made great efforts to create a service of venereal diseases, where teaching could be carried out, but the students appear indifferent and patients object to a service where such cases are exclusively treated, having a false pride about it, and preferring a hundred times over to go to some little doctor on the corner of the street and pay for a consultation, rather than to seek advice in a hospital having the reputation of treating venereal diseases. There appears everywhere in England to be this false pride which makes instruction in venereal diseases difficult. Brooke attempted to combine dermatology and venereal diseases in a little hospital in Manchester. The effort was in vain. Skin patients would not mingle with syphilitics. He then excluded venereal cases, but this was useless, for the former reputation of the hospital for venereal diseases kept dermatological cases away. Possibly there is too much indulgence toward venereal patients in France; but surely there is too much prudery among these patients in England. Syphilis is a reproach and a condition which must be kept hidden. These patients are separated and put to one side or shut up by themselves and are little used for teaching. We merely relate the facts and do not pass judgment upon them. Syphilis is too often innocently acquired to include all cases in the same category, and regard it as always a fault and reproach. All specialists in England are unanimous in wishing to change this state of affairs and regulate the instruction.

On the whole, despite the disadvantages mentioned, we have brought away as a result of our visit and studies an excellent impression. The active spirit and intelligence with which the dermatologists are animated, the ardor with which they enter into their instruction, their admirable manner of teaching, the excellent way in which the dermatological positions are obtained, the intelligent and practical way in which the choice of candidate is made, the encouragement given to young men, and many other good qualities, have permitted us to recognize the practical and serious side of the national character which is so characteristic of the English, and which has contributed to the production of such men as Willan, Bateman, Wilson, and Fox, not to speak of the living, and which has placed the British school of dermatology on a line with the best schools of the world.

LOUIS WICKHAM.

PARIS.



## Selections.

### Formation of a New Bladder by Professor Tizzoni and Alfonso Faggi, of Bologna.

THE above-named authors have attempted to form a new bladder in place of the extirpated one, and for this purpose they used an isolated convolution of the small intestine with the mesentery belonging thereto. Such an isolated convolution forms a tube with muscular walls, lined internally by mucous membrane, very movable, and provided with the necessary vessels of nutrition. This portion of intestine is closed at one end and the other is sutured into the place of the extirpated bladder; on the sides of this piece of intestine the ureters are ingrafted. The experimenters have performed this bold operation upon a small dog (female).

The operation was performed in two *séances*. At the first *séance* a very movable convolution of the small intestine, about seven centimetres long, was isolated, cleaned of faecal matter, and closed at both ends. The one end was stitched anteriorly to the cervix vesicæ. The two severed ends of the small intestine were carefully united by a continuous suture. The abdominal wound was closed. Four weeks later the second step of the operation was performed. The abdominal cavity was reopened; the isolated piece of intestine was sought for and was found to be well nourished but much contracted. The ureters were separated from the bladder and the whole body of the bladder was amputated. After this preparation the lower end of the isolated piece of intestine was opened by a transverse incision and attached to the cervix vesicæ. The ureters were sewed into the sides of the piece of intestine and the abdominal wound was closed. A small elastic drainage-tube was introduced into the newly formed bladder and urethra. During the first few days there was incontinence of urine. Now the dog urinates hourly, passing each time ten to fourteen cubic centimetres of urine. The general health of the animal is otherwise normal.—*Centralblatt für Chirurgie*, xv, 50.

### Contribution to the Treatment of Chronic Tibial Ulcers.

DIPPE reports on the treatment of chronic tibial ulcers in Schweniger's department of the Dermatological Clinic in Berlin. After thorough cleansing and disinfection with a solution of carbolic acid and permanganate of potash, the ulcer is covered with hydropathic compresses which have been dipped into a six-per-cent. solution of sodium chloride. These are renewed every six hours. In case the ulcer after six to eight days has cleared up, then transplantation was performed at once, either according to Thiersch's method, or, if the edges of the ulcers be callous, then one preceded by Nussbaum's method of circumcision, the incision being made two centimetres removed from the edge and extending down to the muscular tissue. In the latter case damp strips of wadding are packed into the wound in order to obtain a broader strip of granulations which takes place in eight to ten days. But in transplanting, Dippe recommends that the pieces of skin be taken as large

as possible. These are held in place by strips of adhesive plaster, which are covered by a well-absorbing dressing, as cotton or moss. The first of these dressings is left on but four days; the others, however, eight.

The after-treatment also consists of hydropathic compresses.—*Mittheilungen aus der dermatol. Klinik der kön. Charité, Berlin, Heft iv.*

### Syphilitic Reinfection with Persistence of Previous Symptoms.

DR. AUGUSTO DUCREY reports ("Giornale Italiano delle Malattie Veneree e della Pelle," December, 1888) the case of a woman, forty-six years of age, who, many years previously, had contracted syphilis while in intimate relations with a woman in the early secondary stage of the disease. There was a complete history of full secondaries, roseola, characteristic pains, adenopathy, etc. Shortly after she married, and, with the exception of a soft sore contracted from her husband, remained healthy for ten years. At the end of that time the husband, after an impure connection, developed an indurated sore, followed by indolent buboes, roseola, mucous patches, etc., and soon after she presented herself for examination. She showed a characteristic gumma of the scalp, multiple cicatrices of pustular and tuberculo-ulcerating syphilides, and atrophic scars of recent date following the reabsorption of dry tubercles, while at the same time she showed a specific and cicatricial induration of the right labium majus, universal polyadenopathy, a maculo-erythematous syphilide on the trunk and limbs, mucous patches on the soft palate and the velum, syphilitic fever, and rheumatoid pains. The coincident infection of the husband, of course, threw much light on the case. The gummatous and tubercular character of the old lesions was unmistakable, the only possible lesion with which they could have been confounded being lupus, from which they differed widely in the character of the sores, the crusts, the age of the patient, and the history of the case. The recent eruption became finally a very wide-spread, small, pustular (acneform) syphilide, which involved every portion of the cutaneous surface but the face; the osteocopic pains became intense and unbearable; ulcerating mucous patches developed, together with extreme tumefaction of the inguinal glands, and a severe iritis of the left eye. At the same time the sore upon the scalp deepened and assumed the unmistakable character of a deep gummatous ulceration. (The condition of the scalp and the general surface at this time is illustrated by two chromo-lithographs.) The case resisted treatment for some time, but was finally cured by means of hypodermic injections of corrosive sublimate. Dr. Ducrey draws the following conclusions:

1. Syphilitic reinfection is possible.
2. It may occur even during the existence of tertiary symptoms due to the preceding infection.
3. The pathological effects of the second inoculation may be precisely those of an ordinary syphilis, with the same succession of identical symptoms; or the second attack may even be one of special gravity.
4. The reinfection of a subject of previous syphilis is not a certain proof that he was cured at the time of the second infection, and therefore the possibility of reinfection is not decisive evidence of the curability of syphilis.—*American Journal of the Medical Sciences, April, 1889.*

### **The Internal Use of Sulphur in Diseases of the Skin and its Appendages.**

IN a recent paper by Sir Alfred B. Garrod (London "*Lancet*," April 6, 1889) on the long-continued use of sulphur in chronic diseases, its internal use in certain skin diseases is mentioned. The popular idea of the value of sulphur in affections of the skin is probably founded on experience, and if any argument is required to add to the probability it is the fact that when taken for any length of time, even in moderate doses, it is eliminated from the skin in a very appreciable degree.

In acne, psoriasis, and prurigo, it is useful either given alone or as an adjunct to other treatment; also in some of the localized forms of eczema, especially those connected with a gouty diathesis, as pruritus ani. It is often most useful in allaying the very troublesome itching of that complaint, an effect probably due in part to the action of sulphur on the skin and in part also to its effect on the hæmorrhoidal vessels. Under the influence of small doses of sulphur when long continued, the complexion of the patient often improves to a marked degree.

"Not long since a lady who had been taking the sulphur lozenge (containing five grains of sulphur and one grain of cream of tartar) for nearly three years told me as a fact, what I little anticipated, that after she had continued the remedy for a short time her finger-nails, which had for a long time been accustomed to split very readily so as to become very troublesome, ceased to do so; but when she omitted the use of the sulphur the brittleness returned. Again, on resuming the use of the lozenge, the nails became healthy and have now remained so for two years."

If the growth of the nail is really altered by the exhibition of sulphur, is it not probable that the hair, another cutaneous appendage, may be also influenced by it? It is certainly worth while to watch and see if an effect of any kind is produced on the growth of hair under these circumstances.

"At present my experience will not allow me to give any definite answer to the question."

### **Electrolysis and the Proper Methods of Using it in the Removal of Hairs and Kindred Operations.**

DR. MORTON PRINCE, of Boston ("*American Journal of the Medical Sciences*," May, 1889), has written an able article on electrolysis and the proper methods of using it in the removal of hairs, and kindred operations. He remarks that all authors who have written upon this subject admit that scars of greater or lesser magnitude necessarily follow the operation, although in the hands of a skillful operator they are reduced to the minimum of disfigurement. The author is satisfied that the fault lies in imperfect methods, insufficient apparatus, and erroneous notions of electro-physics, and that when one can operate under his own conditions, scars, even minute cicatrices, are absolutely unnecessary.

The principal reasons for such disfigurements are either, first, unnecessarily strong currents, or, second, currents of unnecessarily long duration. The first, when not intentional, is due to either (*a*) not using suitable means for

measuring the current, or (b) not using suitable apparatus to insure a definite current of a constant pre-determined strength. To use electrolysis without a galvanometer is to the writer inexcusable, yet he finds no reference to it in works on dermatology. Still, with the batteries usually in use the strength of the current varies immensely during the course of a sitting, owing to variations in the wetness or dryness of the electrodes, the amount of pressure with which they are applied, etc.

To obviate this variability in the current strength, Dr. Prince has introduced the use of a powerful battery (50 to 100 cells) of high electro-motive force with a high resistance introduced into the circuit, instead of the usual weak battery (10 to 15 cells) with low electro-motive force.

One has only to measure the current by the galvanometer before applying it to the body, regulate it to the desired strength, and then apply it with the full confidence that it will remain at a constant strength throughout the sitting, whether the skin be relatively wet or dry.

The apparatus used by the author consists of a fifty-cell Barrett chloride-silver battery, connected with a subsidiary carbon-zinc battery of equal electro-motive force, and in the circuit are inserted the rheostat and galvanometer. A large electrode covered with absorbent cotton serves for the application of one pole to the forearm. A constant supply of hot water is at hand for application to the face during and after the sitting. This largely prevents secondary inflammation. Before the needle is inserted the current is first regulated by the rheostat to any desired strength, the poles being put in contact outside the body, after which the electricity may be applied with confidence and without attention to the galvanometer.

It is on account of the ease and certainty with which a current can be maintained at any desired strength that batteries of high electro-motive force, combined with a high-resistance rheostat, have such an advantage. The length of time a current should be used depends upon the fineness or coarseness of the hairs and the strength of current, and must be left to the individual experience of the operator. Having measured and regulated the current, the next question to be considered is, What strength should be employed? As no two galvanometers register alike, it is impossible to restrict exactly the current strength. The author never exceeds three milliampères as measured by his own Hirshman galvanometer, and considers that a current strength of one half to one millampère is often strong enough.

Experience alone will enable the operator to judge exactly the strength or duration of the current. In operating upon vascular tumors of the skin, moles, nævi, strictures of the urethra, and removal of ingrowing eyelashes, the same methods should be employed.

### **Inflammatory Disease of the Seminal Vesicles.**

DR. JORDAN LLOYD writes in the "British Medical Journal," April 20, 1889, that he is convinced of the not uncommon occurrence of inflammatory diseases of the sexual apparatus lying at the base of the male bladder. The key to much that is puzzling in many of the so-called prostatic and bladder disorders is to be found, he believes, in seminal vesiculitis. This is usually secondary to urethral disease.

It commonly accompanies gonorrhœal epididymitis and originates in the same way. A swelling occurs at one side of the base of the bladder, due in great measure to effusion into the perivesicular connective tissue. It usually terminates in resolution, but may cause suppuration, and pus may make its way into the ischio-rectal fossa or diffuse itself deeply around the rectum. A case is reported in which, without antecedent urethritis, both seminal vesicles suppurated. Deep-seated, smooth, round, fluctuating swellings lying close to the base of the bladder were detected by the finger in the rectum, and upon incision discharged several drachms of pus. Reference is made to a case reported by Dr. Smith, of Baltimore, under the name of hydrocele of the seminal vesicle. Velpeau long since observed that inflammation of the seminal vesicles is not a rare affection in gonorrhœa. The symptoms are essentially those of vesical irritability, uneasiness about the perinæum, painful defecation, frequent and painful micturition, persistent gleet discharge, bloody semen, and painful emissions. Zeissl says the subjective symptoms differ but little from those of prostatitis, but in vesiculitis erections are well nigh constant and so painful as to constitute priapism.

According to the author, objective symptoms are much more reliable and are easily elicited. An elongated swelling is detected by a finger in the rectum. It is beyond the prostate and runs obliquely upward and outward at the side of the base of the bladder.

The swelling is made quite evident to the finger when a metal bougie is passed into the bladder and moved from side to side across the tumor.

Gonorrhœal vesiculitis may be of a mild or severe form, the mild cases being as common as epididymitis.

The following conclusions are the results of the author's experience:

1. That inflammatory disorders of the seminal vesicles and their ducts are not uncommon.
2. That they are in many respects analogous to inflammatory diseases of the Fallopian tubes in women.
3. That while occurring sometimes primarily, they are, as a rule, secondary to inflammation of the urethra.
4. That the ejaculatory ducts may become obstructed and the seminal vesicles consequently hyperdistended.
5. That termination by suppuration is exceptional.
6. That when suppuration occurs it should be dealt with by incision from the perinæum rather than from the rectum.
7. That gonorrhœa is by far their most common originator.
8. That they are frequently concomitant with gonorrhœal epididymitis.
9. That they are usually diagnosticated as inflammation of the prostate or neck of the bladder.
10. That while certain subjective phenomena are suggestive of these disorders, their diagnosis can only be made by objective examination from the rectum and bladder.

### **Xanthelasma, Gout, and Fusiform Enlargements of Tendons.**

DR. J. HUTCHINSON describes a case ("British Medical Journal," April 2, 1889) showing the above combination of affections. The patient had xanthe-

lasma about the eyelids, and his father and paternal grandmother had had the same. He had suffered from several attacks of gout, and when examined showed a swelling half as large as an egg over the right olecranon, about whose base were streaks of xanthoma tissue, but nowhere else excepting about the eyes.

Dr. Crocker recalled a case seen while a member of the Xanthoma Committee. A boy with tubercles of xanthoma around the buttocks had also some fibroid thickening round the joints of the fingers.

Mr. Black had seen fibroid thickening, rheumatism, and xanthoma in combination.

Dr. Herzka, of Carlsbad, said there was every reason to suppose that the altered condition of the blood in gout, etc., had something to do with the production of this disease.

### **Eczema in Childhood.**

IN writing upon the pathology and therapy of infantile eczema in the "Wiener medizinische Wochenschrift," No. 12, 1889, Dr. Schieff says that the study of the causes of the disease, and what many are pleased to call pre-disposition to it, is better carried out in the infant than in the adult. The author bases his paper upon 1,017 skin cases treated in the Vienna Children's Hospital, out of which number 449 were instances of eczema. Eczema capilitii gave 230, eczema faciei 57, eczema universale 30, etc.

The anatomical changes are given as an enlargement and hyperæmia of the vessels of the papillary body, a serous and cell exudation into this and the mucous layer. The papillæ are in consequence elongated and broadened, and so produce the nodule or papule. In greater new formation of cells in the papillæ, and more abundant effusion in the mucous layer and between it and the horny layer, by which the latter is raised up, a bulla is formed. If in such a lesion the quantity of exudation cells increases and becomes greater than the serous fluid, a pustule is formed. In more intense inflammation the corium becomes involved. When the acute eczema goes over into the chronic form we find the papule often extremely enlarged, the vessels increased in caliber, the epidermis and corium thickened, at times pigmentation, indications of increase in connective-tissue growth, and disappearance of the panniculus adiposus. As regards ætiology, it is especially noticeable that eczema appears most frequently in the first and second years of life, 136 cases in the author's table being put down for the first year and 143 for the second.

There are four reasons why this is so:

1. The thinness of the epidermis.
2. The superficial disposition of the papillary body and its plexus of vessels.
3. The comparatively greater turgescence of the skin in the infant compared with the adult.
4. The habitual hypersecretion of the glands of the skin.

The epidermis being thinner, there is more rapid desquamation of the horny layer, and the papillæ and their vascular network lie nearer the free surface and are only protected from external irritating influences by a thin-

ner layer of horny tissue. The skin is thus much more readily affected by irritants, and by reason of the delicacy of its formation the latter much more quickly produce lesions of the tissue than is the case in the skin of adults.

The glandular system of the skin being so active and the product of the glands being so disproportionately rich, we have here one of the most fruitful sources of external injury in the irritation set up by the fatty-acid fermentation products of the skin secretions. These and other disturbing influences do not probably in themselves dispose the child to eczema, but only influence its production in so far as they affect the nutrition, blood-supply, functions, and sensibility of the skin, or possibly in some cases exercise some especial irritant action.

Although among external causes we must place in the first rank an accumulation and decomposition of the natural secretions of the skin, especially in children at the breast, still the number of sources of irritation is infinite. Among them must be mentioned too frequent bathing and rubbing; too long continued baths; maceration of the skin from sweat; acid and alkaline excretions left in contact with the skin; contact with secretions from irritated and inflamed mucous membranes; various physical and chemical agencies; too warm bed-clothing; piercing the ears; scratching occasioned by the burning and itching, such as vermin, scabies, and other conditions produce. When eczema has once broken out, these conditions prolong and aggravate it and cause it to spread.

A mycotic origin of eczema has been suggested, but can not as yet be regarded as proved. It is, however, highly probable, from the configuration, localization, and obstinacy to treatment, that parasitic eczema does exist.

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## Items.

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**American Dermatological Association.**—The next meeting of the American Dermatological Association will be held at Boston, Mass., on Tuesday, Wednesday, and Thursday, September 17, 18, and 19, 1889. The official programme will be printed as soon as it is furnished by the secretary.

**Changes in the Kidneys from Pressure upon the Ureters.**—Dr. Crooke showed at the Pathological Society of London microscopical sections illustrating changes in the kidney due to pressure upon the ureter by a cystic tumor which were histologically analogous, if not identical, with the changes found in granular contracting kidney.

**Suppression of Urine.**—In the "Boston Medical and Surgical Journal" of April 4, 1889, Dr. Farlow writes an interesting history of a case of suppression of urine for twelve days from compression of both ureters. A dense fibrous neoplasm had formed about the ureters near their entrance into the bladder, and had so lessened their calibre as to cause suppression, ending in death. Ovarian tumors have been known to produce hydronephrosis and albuminuria by their pressure upon the ureters.

**Unusual Bromide Eruption in a Child.**—Dr. Beevor showed a child at the Medical Society of London on April 15, 1889, affected with a bromide eruption such as is seldom

seen in the adult. It began upon the arms after a course of bromides in the usual form of an acne-like eruption, which soon simulated a varicella, and ultimately formed condylomatous-like inflammatory nodules.

**The Treatment of Persistent Hypertrophied Mucous Patches in the Female.**—M. Charles Baudier, Thèse de Paris, 1888 ("Archiv f. Dermat. und Syphilis," 1889, i), describes nine cases of hypertrophied mucous patches about the anus and genitals which he observed in Saint Lazare. As he was unable, by means of antisiphilitic treatment extending over several months, to bring about a cure, he applied the actual cautery to the patches, succeeding in a short time by its means in causing their complete disappearance.

**The Influence of Warm Baths on the Elimination of Mercury.**—In the Section for Dermatology and Syphilis of the Third Congress of Russian Physicians, January, 1889, Dr. Borovski gives the following results of his observations on the influence of baths in the elimination of mercury from the system:

1. Warm baths (28°–30° R.), sulphur baths, and dry hot-air baths (50°–80° R.) increase the elimination of mercury, and the body can thereby be entirely freed from the drug.

2. In case the elimination of mercury has entirely ceased, it can, by means of bath, be caused to reappear.

3. Stomatitis mercurialis disappears much sooner under the influence of warm baths.

4. Variations in the temperature of the baths cause corresponding variations in the elimination of the drug.

5. The treatment of syphilis by the combination of mercury and warm baths gives much better results than the use of mercury alone.

6. The beneficial influence of warm baths is to be attributed to their heat, the ingredients of the water (sulphur, etc.) being of minor importance.—*Monatshefte für praktische Dermatologie*, Band viii, No. 8.

**Salol in Skin Diseases.**—In the meeting of the Dermatological Society of Berlin, May 1, 1888, Saalfeld recommends salol in the form of a five-per-cent. ointment as an excellent remedy in impetigo contagiosa and in eczema pustulosum.

The following prescription produced a cure of sycosis parasitaria of several years' duration:

R	Kali carbon.....	1·0
	Ol. olivar.....	10·0
	Zinc. oxid., }	
	Amyli, }	āā 15·0
	Salol.....	5·0
	Sulphur.....	6·0
	Lanolin.....	ad 100·0

**Seborrhœa Sicca of the Scalp.**—Vidal suggests the following:

Sulphur. præcip.....	15·0
Ol. ricini.....	50·0
Ol. theobrom.....	12·0
Balsam Peru.....	2·0

Mix the sulphur and castor-oil thoroughly, then add the cocoa-butter by the aid of a gentle heat, and finally the balsam. Sig.: Rub into scalp morning and evening.

**Lanolin Ointments.**—Stern recommends ("Therapeutische Monatshefte," February, 1889) a mixture of forty parts of soft soap, fifty parts of anhydrous lanolin (lanolin



ordinarily contains about twenty-three per cent. of water which may be driven off by heat), and ten parts of ammoniated mercury, in psoriasis capitis.

For a good adhesive ointment he gives the following formula:

℞ Cer. flav.,	}	..... 5ā 40-0
Lanolin. anhydr.,		
Ol. olivar.....		20-0

M. Ft. pasta usque ad refrigerat. agitand.

It is of a clear yellow color, is easily spread on the skin, and sticks like a plaster. It will serve as a basis for medicinal applications, as, for example, boric acid and zinc oxide. If tar be combined with it, the amount of wax must be somewhat increased. In the eczema of children this ointment is very useful. In squamous and vesicular ailments Stern recommends the following ointment:

Finely powdered salicylic acid.....	3 parts
Olive-oil.....	17 "
Yellow wax.....	40 "
Lanolin.....	40 "

—*Medical Chronicle*, April, 1889.

**Treatment of Psoriasis.**—E. Besnier ("Union médicale," 1889, No. 8) advises the following treatment for psoriasis:

℞ Naphthol β.....	10-0
Adipis.....	90-0

M. et ft. ung.

Apply the ointment with friction every evening to the eruption. On the following morning remove the ointment with warm water and soap, and powder the skin with starch. The treatment may be continued for fifteen days, or until the cure is complete if an amelioration is observed.

**Lanolin Urethral Injections.**—Stern recommends the following formulæ for injection into the urethra:

(1) ℞ Lanolin. anhyd.....	25-0
Ol. amyg.....	75-0
M. Basis injection.	
(2) ℞ Zinc. sulf.....	0-5
Aquæ.....	4-5
Lanolin. anhyd.....	20-0
Ol. amyg.....	75-0
(3) ℞ Acid. salicylic.....	0-25
Ol. amyg.....	75-0
Lanolin. anhyd.....	24-75

Other medicinal agents may be used in like manner.

The first named (basis injection), if held five or ten minutes in the urethra, is mild and soothing. Fat particles are found in the urine for twenty-four hours, and this long retention explains the utility of the drug in gonorrhœal processes. Stern recommends this injection in the acute stage of gonorrhœa.

In eight or ten days he adds antiseptic or astringent remedies, and terminates the treatment by injecting a one-and-a-half-per-cent. solution of resorcin in water. In chronic anterior urethritis, lanolin injections are of special value.

**The Treatment of Corns.**—Dr. C. McDermott writes to the "British Medical Journal" that a saturated solution of salicylic acid in flexible collodion is an excellent remedy for corns. The corns should be painted twice a day. It takes about twelve days for their complete removal.

**Treatment of Warts.—**

R Acid. salicylic.....	1·0
Alcohol.....	1·0
Ether.....	2·5
Collodion.....	5·0

M. S.: Apply daily.

—*Gaz. med. lomb.*, 1889.

**Treatment of Pityriasis Versicolor.—**

R Salicylic acid.....	3 parts
Precipitated sulphur.....	10 “
Lanolin, {	
Vaselin, { .....	āā 50 “

M. To be applied at night and washed off on following morning.

Continued for one week, the treatment will almost always effect a cure.—*L'Union médicale*, February 21, 1889.

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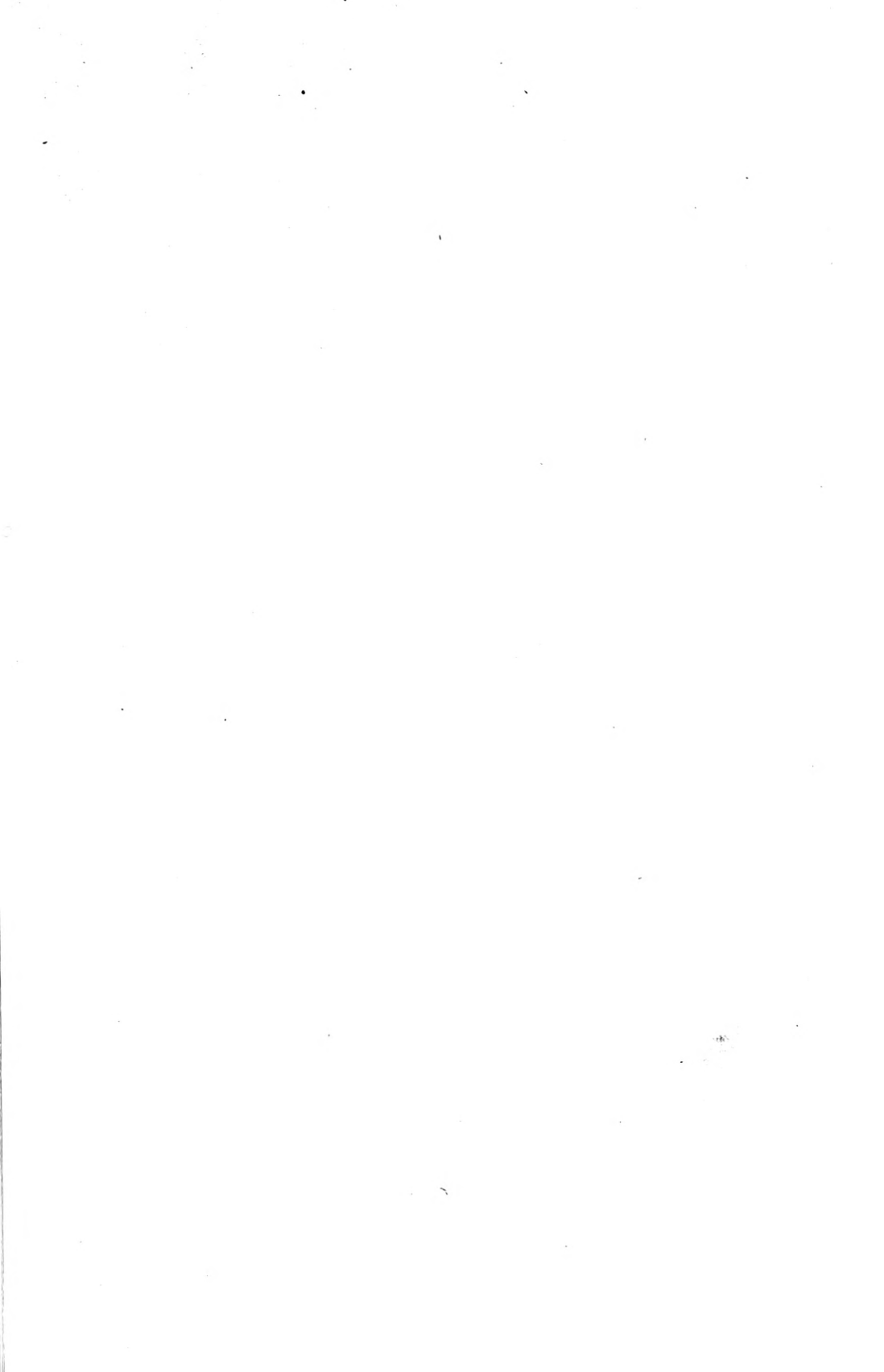
Contributions to the Discussion of the Diagnostic Value of the Tolerance of the Iodides in Syphilis between J. William White, M. D., and H. C. Wood, M. D. By Prof. James Steward, Montreal; Prof. James Nevins Hyde, Chicago; Prof. Fessenden N. Otis, New York; Dr. John P. Bryson, St. Louis; Dr. John B. Chapin, Philadelphia; Dr. Edward N. Brush, Philadelphia; Prof. R. W. Taylor, New York; Prof. F. R. Sturgis, New York; Prof. McCall Anderson, Glasgow; Prof. Edward L. Keyes, New York; Prof. Roswell Park, Buffalo; Prof. William Osler, Philadelphia. [Reprinted from the "Therapeutic Gazette," March 15, 1889.]

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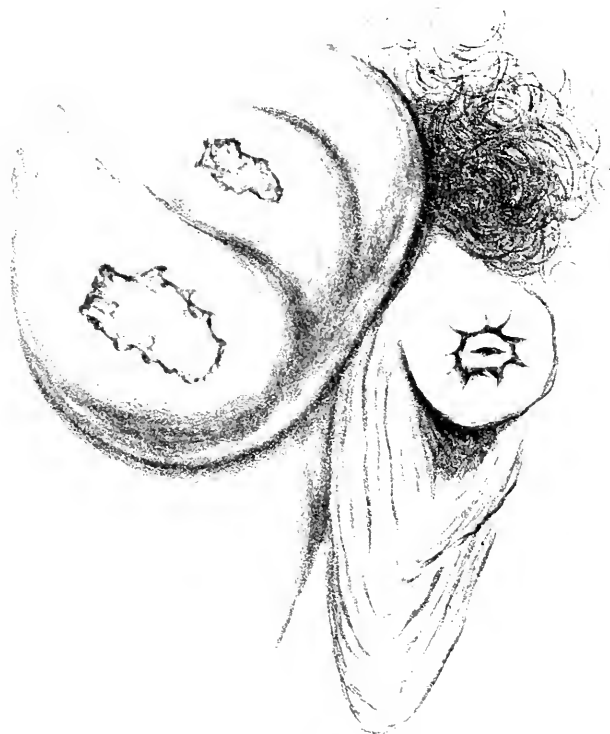


FIG. 1.

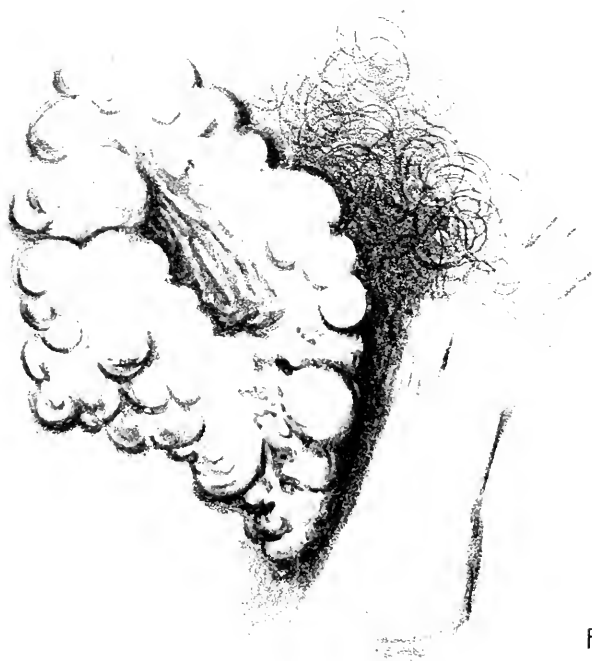


FIG. 2.

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## Original Communications.

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### MALIGNANT TUMORS OF THE INGUINAL GLANDS SECONDARY TO EPITHELIOMA OF THE PENIS.\*

By R. W. TAYLOR, M. D.,  
Surgeon to Charity Hospital, New York.

**B**Y reason of their clinical rarity and of their pathological interest, the two cases whose histories follow are worthy of study and record.

So little exists in literature descriptive of the late and degenerative changes in the inguinal glands in cases of epithelioma of the penis that all carefully observed cases are worthy of a place there. It is probable that the rarity of occurrence of these hideous complications is largely the cause of the present want of knowledge of the subject. Besides showing two well-marked forms of secondary cancerous degeneration in the groin, these cases bring to mind a number of moot points in the clinical history of epithelioma of the penis, which give them additional interest.

CASE I.—M. K., aged fifty-four, a German, single, a tinsmith, was admitted to Charity Hospital, November 8, 1888. He had gonorrhœa twelve years before, but never had syphilis; nor was there a history of cancer in his family. His last coitus was nine years previous to admission. About three years ago (aged fifty-one) he noticed the appearance of warts on the inner side of the foreskin. These grew so that they involved the glans penis and the whole of the prepuce, which was both very long and voluminous. He neither sought medical aid nor took especial care of the organ, so the new growth gradually grew larger. Five months before admission he thinks that ulceration began under the foreskin, but prior to that there was a history of fetid, watery, and sometimes bloody discharge from the surface of the neo-

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\* Read at the third annual meeting of the American Association of Genito-urinary Surgeons at Newport, May 21, 1889.

plasm. Beyond an intermittent sensation of slight pain and heat and burning, he suffered no discomfort.

On admission, the patient was in fair health, had a good appetite, but showed in his face a trace of cachexia. The penis was large and of very dark color, and about two inches from the body it began to expand until it presented a well-marked trumpet-shaped appearance, the circular rim of which, corresponding to the free end of the prepuce, was enormously thickened and more or less grossly fungating. Within this flaring cylinder the glans penis, greatly enlarged, warty and knobby, nestled a little in retreat. In structure the masses were decidedly firm, and in color they were of a grayish-white and dull pinkish-red. The picture of fungoid epithelioma was typical.

The operation was performed by Dr. J. O. Van Winkle, the house surgeon of the division, with the consent of and under the supervision of my friend, Dr. W. H. Van Wyck, and myself, we being then conjointly on duty. The only especial feature of the operation was the adoption of a little procedure which I have used for many years in cases of cancer of the penis in its continuity. This consists in passing two long bonnet-pins through the corpora cavernosa in an X-like manner, avoiding the corpus spongiosum. Before inserting the pins it is necessary to manoeuvre and manipulate a little, so as to get the body of the penis back about three quarters of an inch, and to slide the integumentary sheath correspondingly forward. Then, traction being made and extension and steadiness being thus afforded, the incision is made on the distal side of the pins. The result is that the circular integumentary flap is amply long, laps over, and can be conveniently stitched around the corpora-cavernosa stump. It is, of course, necessary to carry the knife a little forward when the corpus spongiosum is reached (and perhaps to dissect it out), and to cut it through about half an inch beyond the stump, then to split it on each side, and stitch both flaps back on the stump. The operation wound, treated with careful antisepsis, healed perfectly within three weeks, and a well-shaped stump, with ample (perhaps a little redundant) integumentary covering and a perfect meatus (30 French scale), was left, as shown in colored picture, Fig. 1.

The inguinal ganglia on the right side were much enlarged, and on the left side in a lesser degree. The man's condition did not warrant a second or third operation, and it was deemed best to wait until the amputation had healed.

Just as the stump had healed (about the middle of December), without known cause, the ganglia on the right side began to grow larger, and the man became cachectic and lost ground. Examination, in a fortnight, showed a lobulated tumor, of the size of a hen's egg, over which the integument was stretched, and of a dull-red color. Still increasing in size, ulceration began as a small spot of the skin, over the lower part of the tumor, about the holidays. The ulcer had sharply-cut edges and a base of greenish-red necrotic tissue. A foul sanies escaped from it, while a persistent pain was present in the mass. Early in January there were several hæmorrhages from the tumor, some of which were large enough to be threatening. About this time the second smaller ulcer appeared, higher up than the first. The malignant



growth kept on growing until it reached the size of a very large fist, being nearly six inches in length and about five in breadth. Its middle portion was seated just over Poupart's ligament, its base was abutted against the stump, and its apex reached nearly to the iliac crest. It presented a purplish color, an undulating, lobulated surface, and looked like an immense onion imbedded in the soft parts, and projected fully three inches above the skin-level. The appearances are well shown in the colored drawing (see Fig. 1).

As the new growth increased in size the cachexia deepened, and the man died, February 17, 1889, three months after the operation, without having shown any sign of secondary visceral metastasis.

At the autopsy small patches of lobular pneumonia were found in the lower left lobe, the cardiac walls were thin and fatty, the liver in a state of passive congestion and fatty infiltration, and the kidneys were normal. The new growth was found to extend down to the femoral vessels.

CASE II.—J. J., a German, single, a cigar-maker, aged forty-eight, was admitted to Charity Hospital, March 9, 1889. Until within a few months the patient had been in apparent good health, and gives no history of cancer in his family. Twenty years ago he had gonorrhœa and a suppurating bubo in the left groin, which burst and healed. His present disease began about four years ago by the development of warts upon a long but roomy prepuce. His account of his trouble is rambling and unprecise, but the truth seems to be that large warty tubercles formed on the glans and prepuce, which became greatly swollen, and that they soon became ulcerated, and from them a discharge of sickening odor escaped. Three years ago, as the disease had invaded the whole of the pendulous penis, it was amputated at the pubic arch, and a permanent perineal fistula made, through which he has since urinated without trouble. One year after this operation (which would be two years ago), which was done at one of the large metropolitan hospitals, the patient felt a hard lump in his right groin, which grew gradually larger until it reached the size of a hen's egg, when it softened and a quantity of pus and detritus was extruded through the half-dollar-sized opening in the skin. The malignant disease then began in the margins of this ulcer, which became thickened, fungating, and everted, and reached a length of about two inches and a width of an inch and a half. The fungous growth thus produced at once began to grow larger, and as it did it flattened out and thereafter increased at its periphery rather than in height. To-day it can be seen in its full development (see Fig. 2 of the chromo-lithographic plate). It consists of a raw, red fungous mass, nearly six inches long by four inches at its widest part, and a little more than an inch in height. It follows the line of obliquity of Poupart's ligament, extends from near the crest of the ilium to the inner surface of the thigh, and reaches from about an inch and a half above the crural arch downward on the thigh for nearly three inches. It is an irregularly ovoid mass, or rather a ring or a collar, having a festooned margin and a decidedly lobulated appearance, caused by the promiscuous conglomeration of a vast number of fungoid tumors. Within this ovoid ring is a blackish chasm, the bottom of which would seem to be the deep fascia, covered with foul, greenish-black necrotic tissues. On the site of this chasm the neoplasm began in the glands, which softened and underwent decay, but it continued to grow at

its periphery until it had produced the epitheliomatous lesion now depicted. The fungoid masses, which are as firm in structure as boiled bacon, present a red, raw appearance, are here and there covered with pus, give rise to a disgusting odor and cause the patient some physical pain and great mental worry. The rate of increase of this new growth is now scarcely perceptible. There is not much enlargement in the left groin, as the glands were years ago pretty well disorganized, and the penis is absent. In this state the man remains cachectic, worried, and hopeless. He gives no symptoms of further metastasis of the epithelioma, and his death, which is inevitable, will perhaps be due to the deepening of the cachexia or perhaps to one or more visceral new growths.

The first point of interest in these cases is the origin of the disease in men aged, respectively, fifty-one and forty-four, in what seemed to be simple vegetations of the penis. Whether these new growths were benign in character at first we are unable to say, as is usually the case; nor can we tell when malignancy began. But their subsequent course showed that it is very probable that they became cancerous quite early. In the first case the penis became so large, unwieldy, and ulcerated at the region of the glans and prepuce, in rather less than three years, that amputation was necessary, while in the second the cancerous growth in a younger man involved the whole penis in a year. The experience here recorded is in keeping with that of most observers—namely, that in from one to three or four years the disease becomes developed to a threatening extent. Then, again, we sometimes see months and even years elapse during which the epitheliomatous growth remains small in size.

Besides these interesting points as to the growth of the malignant neoplasm, the teachings of these cases convey a very forcible lesson—namely, the tendency, which becomes more marked as we get beyond the fortieth year of life, for inflammatory and simple hyperplastic growths of the penis to become malignant in their nature. The obvious fact remains that when palliative treatment does not relieve balanitis of any kind in these cases, circumcision is imperatively indicated, and that when simple vegetations are present they should be removed promptly and thoroughly before a cancerous nature becomes ingrafted upon them. In these particular men the habits of cleanliness and care of the person were not well marked, therefore little was done to prevent the disease at the outset and less when it became firmly established.

Much has been written and many statistics have been given concerning the date of infection of the lymphatic ganglia in the groin in cases of epithelioma of the penis. The truth is that we are unable to state even approximate facts. Some cases are not seen early and for a sufficient length of time; others are but indifferently observed; and, further, in some the date of ganglionic infection is quite early and in others more delayed.

Then, again, it will be evident to any one familiar with the literature of

epithelioma that all statistics as to the proportion of cases in which the ganglia are affected, and the reverse, are entitled to no weight whatever, since they are gathered indifferently from those who observe their cases with care and precision and those who do not.

Gussenbauer\* very truly says that the neighboring lymphatic ganglia are more frequently involved than we have been in the habit of thinking, and that in nine operated cases gland infection was found, and twice with the aid of the microscope. It is very probable that minute malignant changes may take place in their structure which are not evident to our most careful palpation. It may happen that in some cases the lymphatic glands are not involved; indeed, I have seen epithelioma of the penis exist for six years before amputation, and the patient lived years thereafter without any secondary metastasis of the disease. Kaufmann† says that the general impression that the glands in cancer of the penis are not diseased in toto is correct, but that out of forty-eight operated cases only eight were seen in which there was no glandular change; hence that it happens in the majority of the cases.

The clinical features of epitheliomatous glands are not adequately treated of by most authors. Paget‡ gives about the sum of the matter when he says: "The diseased glands are enlarged, hardened, smooth-surfaced, and usually retain their natural connection with the surrounding tissues." My two cases show two distinct phases of malignant growths in these structures in an admirable manner. In the first case the new growth in the glandular structures was very exuberant, and a very large subcutaneous, lobulated mass was produced which caused ulceration in the skin. Though the superficies of the mass underwent decay, its central portions retained their integrity. During its development there was erosion of one or more small arteries. Case I, therefore, represents an unusual exuberance of epitheliomatous growth in these ganglia.

In Case II a different order of phenomena may be observed. In this case it seems probable from the history that the cancerous glands underwent acute inflammation, that suppuration ensued, and that they were thus extruded. Around them, however, the malignant action had established itself, perhaps in the skin or connective tissue, and perhaps in both. Having begun in the circular abscess cavity, it increased rapidly until it produced the red, raw, fungating, lobulated ring of malignant tissue shown in Fig. 2 of the colored plate. The morbid process, therefore, in the first case was quite sharply limited to the glands, with perhaps some

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\* "Ueber die Entwicklung der secundären Lymphdrüsen-Geschwülste," "Prager Zeitschr. für Heilkunde," 1881, Band ii, p. 17.

† "Verletzungen und Krankheiten der männlichen Harnröhre und der Penis," Stuttgart, 1886, p. 275.

‡ "Lectures on Surgical Pathology," Philadelphia, 1865, p. 617.

secondary tegumentary change: in the second, it began on the glands and destroyed them, and then spread to the overlying and surrounding skin. It seems singular that a number of such cases have not been described and figured before, but beyond the slight details of a case of Demarquay,\* and the statement of Paget† that acute inflammation may attack cancerous glands and lead to cancerous ulcers, I have been unable to find any mention of the fact. Kaufmann, however, relates a case in which epithelioma of the penis began about the same time that a cancerous ulcer appeared in the groin.

The involvement of the inguinal ganglia in epithelioma of the penis is inevitably followed by death at an early or late date. Operative procedures in cases like these would be simply surgical vandalism, since it is impossible to remove all of the diseased tissue. Secondary degeneration of cancerous ganglia elsewhere may be attended with similar clinical features.

The interesting fact is brought out in my first case that there was no further metastasis of the malignant growth beyond the ganglia. In this its teaching is in accord with the experience of all other observers, who say that it is rare to see a general diffusion of malignancy in cases of cancer of the penis. According to Kaufmann,‡ the viscera were seen to be secondarily affected, by Winiwarter in one case, by Ricord in one, by Lebert in two, and by Louis in one case, making in all six in literature. Death in epithelioma, therefore, as a rule, results from the general cachexia induced rather than from metastatic growths in some vital organ or organs.

Epithelioma of penis of Case I.  
See Fig. 1.

Epithelial invasion of foreskin, showing ulceration in center and involvement of papillae and mucous follicles with epitheliomatous elements and the so-called "nests" or "pearls." Alum carmine, magnified 75.

Inguinal glands, secondary involvement to epithelioma of penis of Case I. See Fig. 2.

The alveolar arrangement of epithelial cells is shown in the gland structure. The alveolar arrangement is depicted filled with flat cell epithelium invading the



FIG. 1.—SECTION OF GLANS PENIS THROUGH  
EPITHELIOMATOUS MASS.  $\times 75$ .

\* "Maladies chirurgicales du pénis," Paris, 1877, p. 371.

† *Loc. cit.*, p. 617.

‡ *Loc. cit.*, p. 277.

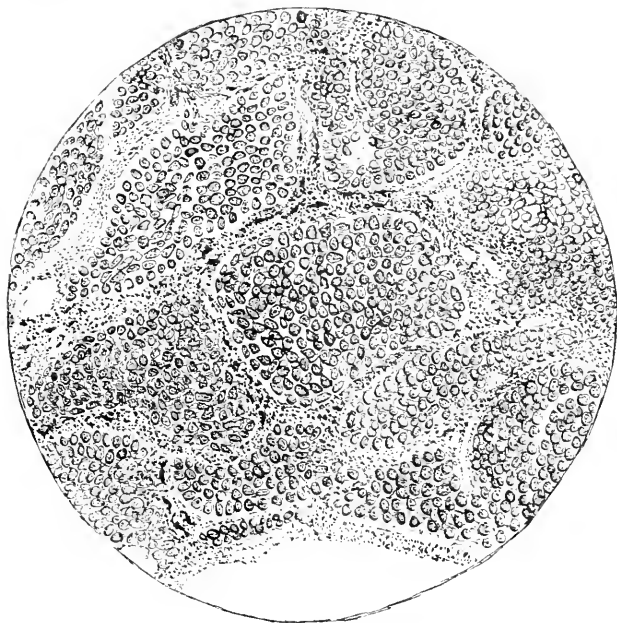


FIG. 2.—INFECTED INGUINAL GANGLIA FROM EPITHELIOMA OF PENIS. CAMERA LUCIDA DRAWING.  $\times 200$ .

inguinal glands and surrounding tissues and similar to primary carcinoma of other glands. Camera lucida drawing. Alum carmine, magnified 200.

Epithelioma in new connective tissue, secondary to epithelioma of penis of Case II. See Fig. 3.

The true gland tissue, being first involved, has sloughed, and new granulation tissue has sprung up in its place. The new tissue has been invaded with epitheliomatous elements from contact. Upper part of cut shows the typical alveolar arrangements, with bundles of new connective tissue between the alveolar spaces filled with epithelial cells. Lower portion of cut, still granulating tissue from



FIG. 3.—EPITHELIOMA OF CONNECTIVE TISSUE, SECONDARY TO EPITHELIOMA OF PENIS.

small cells, bundles of connective tissue more formed, the whole mass invaded here and there by rapidly growing flat cell epithelium. Hæmatoxylin and eosin, magnified 200.

It will be seen that the results of microscopic examination of the inguinal tumors of Case II are entirely in accord with the clinical history.\*

## PRIMARY SYPHILITIC LESIONS AT THE MEATUS URINARIUS.†

By F. B. GREENOUGH, M. D.,

Boston,

Clinical Instructor at the Harvard Medical School.

UNLESS my experience has been an exceptional one, cases in which the syphilitic virus has obtained an entrance into the system at or in the vicinity of the meatus urinarius are not so very uncommon. Having seen several such, and having thought that two or three points of practical interest are to be deduced from their observation, while not attempting to cover the ground which the subject opens, or to refer to its literature, I venture to ask the indulgence of the association during the short space of time I shall occupy in referring to them.

A typical primary syphilitic lesion—that is, an induration of tissue with a lesion of continuity of its integument, consisting either of a slight abrasion or actually showing loss of substance as the result of ulceration—when situated at the meatus must of necessity, from its anatomical position, be subjected to an influence which it would escape if situated elsewhere, as, for example, on some other part of the glans penis, in the sulcus, or on the prepuce, namely, the fact of being washed over several times daily by the urine, which is more or less irritating, according to the character and the amount of the chemical ingredients which it contains. *A priori*, one would infer that this daily washing by a fluid more or less irritating would act as an obstacle to the healing of the lesion, and such seems to be the fact. In some cases the pain during the act of micturition is very severe, and the abraded or ulcerated surface looks angry and surrounded by a red inflammatory areola, showing that the sore has been irritated by some external cause. A similar condition, due to the same cause, is seen in those cases of venereal sores at the margin of a long prepuce where a phimosis exists, either inflammatory or due to specific sclerosis, which likewise are washed daily by the urine at every act of micturition, and which likewise prove to be extremely obstinate in healing. In both of

\* The microscopic examinations and drawings were made for me by my friend Dr. E. M. Culver.

† Read at the third annual meeting of the American Association of Genito-urinary Surgeons, at Newport, May 21, 1889.

these cases the pain can be much lessened by iodoform dressings, by local applications of cocaine a short time before passing water, and also by immersing the penis in a basin or bowl of tepid water during the act of micturition, the urine being largely diluted by this means as soon as it is voided.

Given a venereal sore, appearing at the meatus after an exposure, the question as to diagnosis lies between the true syphilitic chancre or primary lesion and the chancreoid, and in this connection the irritating action of the urine on the sore is of considerable importance. A chancreoid at the meatus, subjected to the constant irritating action of the urine, may develop such an amount of inflammatory induration of its edges and base as to be with difficulty distinguished from the sclerosis of the true chancre, especially as in this situation the latter is not always very well marked. Also when a chancreoid involves the whole circumference of the meatus, especially if it is irritated or has destroyed much tissue, glandular reaction in both groins may be found, instead of on only one side, as is the case when the chancreoid is unilateral. In point of fact, the diagnosis between a true chancre and a chancreoid in case of a lesion at the meatus is in some cases by no means an easy one to make at once. It is, however, important that it should be made, especially when the sore is very painful, involves much tissue, or shows a tendency to spread rapidly, as, if it is syphilis, it will almost invariably yield in a surprisingly short time to constitutional specific treatment, while, on the other hand, to put a patient on specific treatment when the diagnosis is open to doubt may possibly be the cause of a great deal of uncertainty and unhappiness for him in future life. Even the local influence of a lesion at the meatus may not cease when healed, as, according to the amount of tissue involved, there may result more or less of a cicatrix, the subsequent contraction of which may cause trouble and require treatment.

The possibility of malignant disease in this locality with regard to the question of diagnosis need only be referred to in this connection. So far, I have considered primary lesions which, in addition to a specific induration, showed a certain amount of abrasion or even ulceration; and this condition of the surface is found in the great majority of true syphilitic chancres, taken as a whole—that is to say, on whatever part of the body they may be found, their situation, of course, depending upon where the syphilitic virus happened to have been absorbed. While occasionally instances are seen on the prepuce, glans penis, or even in the sulcus, where no loss or alteration of the surface can be noticed, the swelling and induration of the tissues with some congestion being the only abnormal conditions found locally, such are most certainly exceptional.

On the other hand, of the cases that have come under my observation, quite a large proportion of primary lesions at the meatus have consisted simply of induration of the underlying and surrounding tissues, without

any lesion of continuity of the surface at all, and this seems to me to be one of the most interesting and important facts connected with the subject.

The induration even may not be very well marked, and I have never seen a case in which it showed itself as a well-defined, elevated, hard lump, such as is seen on the looser tissue of the prepuce and elsewhere.

Even when developed to such a degree that when you take the end of the glans between the forefinger and thumb it feels as though you had hold of a piece of gristle, to inspection there will be little, if any, change in the shape of the glans. The mucous membrane around the meatus, although by no means normal, looks congested simply, and perhaps shiny, and the lips rather puffy—very much as they do in some cases of chronic gleet. I must confess that my interest was, in the first place, especially called to these cases by having one that had been sent to me as a case of “obstinate gleet” suddenly blossom out with a full-blown macular syphilide and the other symptoms of syphilitic constitutional infection. This was many years ago, and I have not been caught again, but I have seen several cases in which I know this error in diagnosis had been made, and also others from whose history and symptoms I feel sure it had been.

In fact, I am inclined to think that many of those cases, which every specialist sees, where undoubted constitutional syphilis exists—and the patient, with apparently perfect sincerity and with no conceivable motive or reason for deception, insists that he never had any venereal trouble beyond a slight clap, or even perhaps nothing more than a “strain”—are to be explained by a previous not recognized primary lesion at the meatus rather than by the supposed urethral chancre, on whose shoulders these cases usually are laid. Of this urethral chancre's existence I must say that I have never been able absolutely to convince myself.

Inasmuch as quite a number of the cases which I have seen, in which primary lesions at the meatus were not recognized as such on account of the absence of any alteration of the surface, were either seen in consultation or sent to me by other physicians, undoubtedly from the very fact that they did not show the condition which is usually seen in a true chancre, it would be obviously unfair to draw any deduction from them as to the relative frequency of such cases. I have, however, seen enough in my own practice from the first, and followed up, to convince me that of primary lesions at the meatus a very much larger proportion consists of simple induration without loss of tissue than is the case in any other situation. I regret not having actual records as to the relative numbers of these cases, and am aware that not having them makes my statement merely a matter of opinion; but it is only as that I give it.

The amount of induration found varies very much, in some cases barely extending beyond the margin of the meatus.

Under these circumstances it is easily conceivable that a case which is



only glanced at occasionally might not be recognized in its true character. Such a mistake would, of course, be even more probable when, as I have known to have been the fact, a case of supposed urethral disease was treated for some weeks without the patient's having been once asked to unbutton his trousers. On the other hand, the induration may involve nearly the whole glans, being most developed at the meatus, and may be so well marked as to feel almost cartilaginous; but even then the general contour of the glans is very little altered. It may look rather swollen and perhaps larger generally than normal, but there will not be any one raised spot to suggest the center of disease.

In the cases heretofore referred to the meatus has been exposed—that is to say, not covered by a long foreskin. I have, however, seen some where a long prepuce in a condition of phimosis completely covered the glans and prevented a sight of the meatus being obtained, and it was only after the phimosis had been subdued and the prepuce could be retracted that the induration found at the meatus showed exactly what the source of trouble had been. These cases of acute phimosis with subpreputial disease of some kind, swelling and induration of the parts, and more or less abundant purulent discharge, are often most interesting and puzzling in the way of diagnosis; but in this connection I will merely say that the possibility of a primary lesion at the meatus being the original cause should be borne in mind.

Where the meatus is open to inspection, of course the diagnosis is less difficult, and there are other symptoms to be taken into consideration besides the mere primary lesion itself; nevertheless, I think, not infrequently syphilis is not recognized when just manifested at this locality, on account of the absence of ulceration and of an elevated induration evident to the eye, which conditions are found in a certain number of primary lesions there situated.

It is, however, when these lesions are complicated by coexistent urethral trouble that they assume an especial interest to the physician, and may be a source of annoyance, and even of serious trouble, to the patient.

It is evident that a hardening of the tissues surrounding the meatus, to such a degree as to decidedly contract its orifice, must practically have the same mechanical effect on the proper emptying of the bladder that a contraction to the same degree anywhere else in the course of the urethra would have, so far as its being an impediment to the free passage of the urine. In other words, a sclerosis at the meatus is for all intents and purposes a stricture, and when a urethritis is complicated by such obstruction it is evident that the same aggravation of symptoms may occur as does in cases of urethral stricture; that is, the contraction of the caliber of the urethra at the meatus, as well as elsewhere, may cause an exacerbation of any inflammatory process already existing, and give rise to the

same complications, of which complications an extension of inflammation to the bladder is the most frequent and most important.

The smaller the meatus is, the more likely will any induration of its surrounding tissues be to cause trouble. Every practitioner who has been interested in urethral pathology must have seen that a patient whose meatus was decidedly below the average size was heavily handicapped by that fact. A small orifice which may be large enough to allow a proper evacuation of the bladder in a state of health will, when inflammation of the urethral mucous membrane starts up with a purulent and irritating secretion, not be able to give sufficiently free drainage and flushing. It is not infrequent in these cases of congenitally small orifice that even after a mild attack of gonorrhœa the meatus has to be enlarged before the mucous membrane can be brought back to its normal condition. Such a case would, of course, be still more complicated and aggravated if, in addition to the natural smallness of the meatus, it were still more contracted by the unyielding induration found in a syphilitic primary lesion.

Moreover, without having any absolute proof of the fact, I am inclined to believe that a primary lesion at the meatus, especially if the latter is small, may be the cause of urethral trouble, instead of simply aggravating previously existing disease. If that is possible, the other complications of bladder, etc., might follow. In most of the cases I have seen, however, previous urethral trouble had existed, and I should also say decidedly that in most of them the meatus was below the average size. If this is correct, it naturally suggests the possibility of these two facts—i. e., previous urethral trouble and a small meatus—being predisposing causes to the absorption of the syphilitic virus at this point.

Theoretically, this seems plausible. A small meatus, in the irritated condition in which it is often found in cases of chronic gleet, certainly would seem to be more likely to absorb any virus with which it might come in contact than one the mucous membrane covering and surrounding which was in a perfectly healthy and normal condition. Is it not also possible that one of the small follicular openings which are so often seen at the margin of the lower part of the meatus in cases of chronic gleet, resulting from previous follicular abscesses, may be the door through which the syphilitic virus enters? And is it not conceivable that a primary lesion due to the entrance of the virus into an open follicle might be less likely to show changes of the surface than when the poison had been absorbed through a crack or abrasion of integument, as is usually the case when the infection has occurred at the more common situations? I will condense from my case-book the record of a case which illustrates several of the points which seem to me to be interesting in this connection, and which is a typical one of some that I have seen, varying only in the degree to which the symptoms had progressed :

CASE.—The patient, a shop-keeper about thirty-five years old, came to me in the winter of 1882 from a general practitioner who had been treating him for gonorrhœa, which had latterly been getting more acute daily and which at that time was very severe, and the symptoms, instead of yielding, had been steadily increasing in severity. The appearance of a "general rash" was the cause of my seeing the patient. On examination, he was found to have a very generally distributed macular syphiloderm, crusts on the scalp, enlargement of the inguinal lymphatic glands in both groins and also of the post-cervical ones, and a marked congestion of the mucous membrane of the fauces. The glans penis in the vicinity of the meatus looked slightly swollen generally and congested, but no abrasion was seen. A very decided induration was felt at the meatus and around it. The orifice, which evidently was small normally, was contracted by the surrounding induration to the size of a No. 4 shot or small crow's quill, and an abundant, thick purulent discharge welled out on pressure. He complained of great pain in micturating and severe chordee at night. Micturition was frequent, and, when the desire to pass water was felt, it could not be controlled. The amount passed would often be very small in quantity, and each act of emptying the bladder would, besides scalding excruciatingly at the time, be followed by severe tenesmus. The urine was heavily loaded with pus; in short, the patient, besides having constitutional syphilis, was suffering from a quite acute attack of cystitis.

Urethral injections, which he had been using continuously, were stopped, and he was put on a course of mercurial treatment, pushed actively at first.

The meatus was dilated by the constant use of a tampon of absorbent cotton rolled up tightly and smeared with mercurial ointment.

The rapid improvement of the patient, especially with regard to the bladder symptoms, was most satisfactory. The induration at the meatus softened down and the orifice gradually dilated, the pain and tenesmus disappeared, the discharge became less in quantity and thinner in quality, and the urine showed less and less pus. About three months after he was first seen, I find the record that for some time his urine had been perfectly normal and that all urethral and bladder symptoms had ceased. The syphilitic symptoms also yielded rapidly; but of these he later had a relapse.

This case is quoted rather fully because the bladder was so decidedly and severely affected and yielded so quickly to the mechanical dilatation of the contracted meatus with the important help of constitutional treatment.

This case is one of those in which I am inclined to think the whole trouble of the urinary tract was due to the obstruction at the meatus as a primary cause rather than as an aggravating influence acting on a case of gonorrhœa previously existing. Of this, however, I have no proof to offer unless the fact of the trouble's yielding quickly and entirely to the removal of the obstruction be such.

There are few, if any, diseases which come under the care of the medical practitioner in which the results of appropriate treatment are so surely and quickly beneficial as is the case when constitutional syphilis is first

treated. When, in addition to the disease itself, we have grave symptoms of so important an organ as the bladder caused by a syphilitic lesion, it is doubly our duty to avail ourselves of the means which medical science places in our hands. A great deal, therefore, depends on our being able to arrive at a correct diagnosis, which is by no means always easy. If syphilis is correctly diagnosed, the results of treatment will be probably very marked. The continuously wearing a tampon smeared with mercurial ointment is a great help. The patient, if he is at all handy at manipulation, will soon be able to roll up a conical plug, and, by making it a little larger each time, considerable stretching can be obtained rapidly. The use of mercurial ointment on it undoubtedly hastens the softening of the induration.

One patient acquired a great deal of skill in fitting these tampons. When he removed one, it would come out almost with a flop, looking like a small mushroom, the stem having fitted tightly into the meatus and extended about three quarters of an inch into the urethra, and the upper portion being molded to fit flat on the extremity of the glans, thus getting the action of the mercurial ointment on the indurated tissue surrounding it as well as on that of the meatus itself. When the plug is well fitted and large enough, the meatus will, when it is pulled out, remain for a time at least patent, looking like a circular hole with slightly raised edges.

It might be necessary, in a case where the symptoms of obstruction were very urgent, to resort to meatotomy, after which the same use of the tampon would be useful.

The facts with regard to primary lesions at the meatus, which I have attempted to call attention to, may be briefly recapitulated as follows:

That, when abraded or ulcerated, from their anatomical position they are subjected to the daily irritation of the urine, and therefore are apt to be rebellious to treatment.

That a chaneroid at the meatus is also subjected to this same source of irritation, and may consequently develop enough inflammatory induration to cause a doubt as to the diagnosis.

That a certain and not a small proportion of primary lesions at the meatus do not show any loss of surface, but are simply scleroses, and in some cases not even well-marked ones.

That consequently they may be, and not infrequently are, not recognized, but are mistaken for the condition which is seen at the meatus in cases of chronic urethral disease.

That they are, as a rule, found in cases that have a history of previous urethral trouble, in which also the meatus is smaller than the average.

That possibly the fact of the meatus having been in an unhealthy condition may account for the syphilitic virus having been absorbed at that point.

That a marked induration at the meatus may aggravate any pre-existing or coexisting urethral disease, and perhaps even cause such, and that serious inflammatory complications may follow.

And that a recognition of the true character of these lesions is important, as they yield quickly to constitutional specific treatment, which is helped very decidedly by the continuous use of dilating tampons locally.

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#### GENITO-URINARY NOTES.\*

*Serpiginous Chancroid of the Vagina, involving a Branch of the Anterior Trunk of the Internal Iliac Artery, the Sacro-sciatic Ligaments, etc.; Death from Hæmorrhage.*

*Case of Hunterian Chancre in the Female.*

By ALEXANDER W. STEIN, M. D.,  
Surgeon to Charity Hospital (Genito-urinary Division), etc.

**S**ERPIGINOUS CHANCROID OF THE VAGINA.—J. R., aged twenty-five, married, admitted to hospital June 26, 1887. Family history good. Has always enjoyed excellent health. Commenced to menstruate at the age of sixteen, since which time her menses have recurred at regular intervals. Has not been pregnant.

One month before her entrance to hospital she contracted a sore from her husband, and two weeks afterward noticed a copious purulent discharge issuing from the vagina. Recently her left thigh commenced to pain very much when walking, especially in the vicinity of the hip and knee joints. Has a scalding pain during micturition. On examination, there was a thick foetid pus flowing from the vagina and a large phagedenic chancroid was found on the left wall, extending from the labia minora inward to the extent of two inches and a half. The inguinal glands in the left groin were enlarged. Much tenderness was complained of on pressure between the trochanter major and the tuberosity of the ischium of the left side. She limped in walking. The chancroid was cauterized with nitric acid and dressed for a while with a solution of permanganate of potassium, under which treatment the sore improved in appearance. During the month of July the sore continued to improve and heal under the use of vaginal douches of acid. carbol., 3 ss., to aqua, Oj, and iodoform dressing, with packing of the vagina with absorbent cotton to keep opposed surfaces dry and apart. Her general health declined, she lost appetite, and, with disturbed rest, became emaciated and much weaker. The joints were not inflamed and the cause of the persistent pain could not be determined.

Aug. 9. The house surgeon was called and found she had had a

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\* Read at the third annual meeting of the American Association of Genito-urinary Surgeons, at Newport, May 21, 1889.

hæmorrhage from the vagina. It had ceased before he arrived. It was learned that during the night and early morning she had several hæmorrhages. The source of the bleeding seemed to be from the surface of the vaginal ulceration, which was covered with clots of blood. A piece of cotton saturated with liq. ferri persulph. was placed *in situ*, and the patient given morphine and spt. frumenti by the stomach.

Sept. 5. Had a recurrence of several small hæmorrhages up to date. They ceased, however, before the house surgeon could see her. The thigh now became more swollen. She could scarcely bear the weight of the bed-clothes. Could not move the limb. It was elevated on pillows and lotio. plumbi et opii applied. Stimulants and morphine continued, with tr. ferri chlor. internally.

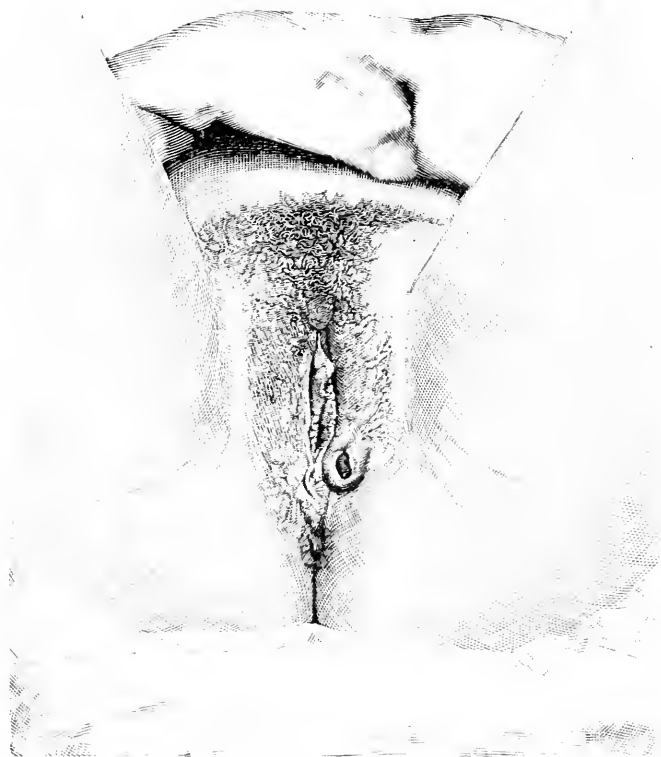
Sept. 6. Had retention of urine. Catheter passed this evening and about fourteen ounces of healthy urine drawn off. She passed her water the following morning *per viam naturale*, but in the evening had to resort to the catheter again.

Sept. 10. This morning, while the house surgeon was in the ward, patient said: "Doctor, I am bleeding." She was immediately examined, the mattress was found saturated with blood, and a small stream of arterial blood was pouring from the vagina. Patient appeared almost exsanguinated and on the verge of syncope. As speculum was introduced and the vagina tamponed with cotton, saturated with liq. ferri persulph. The hæmorrhage was at once controlled, apparently. Complained much of leg while this was being done. Warm bottles were applied to the extremities, whisky and morphine injected hypodermically, but without avail. She died from exhaustion. Hæmorrhage occurred at 11.45 A. M., and death at 1.15 P. M.

*Autopsy* twenty-four hours after death: Body small, emaciated, and presented a blanched appearance. Rigor mortis almost absent. The thoracic and abdominal viscera were very markedly anæmic. There were some old pleuritic adhesions. The pericardium was two thirds filled with a passive effusion. Adhesions of liver to diaphragm from old perihepatitis. Otherwise there was nothing noteworthy. All the pelvic organs were removed *en masse*. Vagina firmly tamponed with cotton, saturated with liq. ferri persulph. A superficial ulceration on the left wall of the vagina involving little more than the mucous membrane. One inch above the left labium minus was a minute perforation with pigmented edges, leading by a sinuous tract obliquely upward and backward to a moderately firm and flattened tumor occupying the whole left side of the pelvic cavity. This mass, on examination, proved to consist of blood in various stages of coagulation. The persistent pain that the patient suffered from was doubtless due to pressure of this intrapelvic mass upon the nerves supplying the left lower extremity. The pelvic fascia was thickened and the glands of the

pelvis enlarged. The serpiginous character of the phagedenic ulcer did not spare, as is usual, fibrous tissue and blood-vessels in its progress. It had destroyed the lesser sacro-sciatic ligament, throwing the two foramina into one, eroding the external surface of the spine of the ischium and burrowing behind the acetabulum and side of the sacrum and coccyx, disintegrating the muscles of the gluteal region and extending its ravages to within three fourths of an inch from the surface of the skin. Exploration for the source of the hæmorrhage revealed an erosion of one of the branches of the anterior trunk of the internal iliac artery.

HUNTERIAN CHANCRE IN THE FEMALE.—S. II., aged nineteen, domestic. Two weeks since, while menstruating, she noticed an unnatural sore-



ness about her genitals, and found, upon examination, that there was a large pimple situated below the left labium majus. This pimple, she says, broke and gave place to an ulceration, which for a short time continued to enlarge. The ulcerated surface is now, March 11th, situated upon an indurated base. It is quite dry, its edges are sloping, not undermined; it is not

at all painful and only slightly sensitive on handling. The inguinal glands on the left side are very much enlarged and indurated, while on the opposite (right) side they are very little larger than normal but quite hard. Her epitrochlear and post-cervical glands were also somewhat enlarged. She did not develop any syphilodermata as far as we know, but on April 8th she complained of sore throat, and the examination revealed a distinct mucous patch on the left tonsil. Internal treatment, which up to this time had been delayed, was now commenced, hyd. prot., gr.  $\frac{3}{8}$ , with an astringent gargle three times daily until April 20th, when she complained of tenderness of the gums, and, as the mucous patch had disappeared, the treatment was discontinued. The primary sore, which up to this time had been dressed with hyd. oxid. nig., now consisted only of a hardened base, the ulceration having completely cicatrized. April 28th, patient again complained of sore throat, and there was a mucous patch on right tonsil, which was touched with argent. nitrat. and a gargle, and specific treatment again resumed until May 6th, when the patch had entirely disappeared. There being no other syphilide present, she was discharged, with the injunction to keep herself under treatment and under observation from time to time.

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### GALVANISM IN THE TREATMENT OF PARASITIC SKIN DISEASES.\*

By J. A. WESSINGER, M. D.,  
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HOWEVER different in their pathological bearings or in the clinical features that accompany them, the class of skin diseases to which I wish to direct your attention for a few moments to-day have one thing in common, viz., a microscopic vegetable organism as their chief aetiological factor. However well we may familiarize ourselves with the proper hygienic surroundings of the patient, however thorough our methods of managing the nutrition of the afflicted person may be, if we fail to effectually eradicate the active cause our patient will have sought relief in vain. This truth is so plain and elementary as to require no elucidation from me. We all, no doubt, have had occasion to treat cases of this class of skin diseases where thorough treatment was carried out for months, and yet the patients be obliged to go away without having been relieved of their malady. It has been my experience that no class of skin diseases are so

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\* Read before the Michigan State Medical Society, and printed in this Journal with the consent of the society.



intractable to treatment as those brought about through the presence and operation of a vegetable organism. I am aware that there are those who maintain that thorough epilation and the application of cleanliness with the usual parasitocides will relieve these patients in from three to four weeks. I think I have been in exact accord with authorities in these usual methods of treatment. I have tried to follow their methods closely, and yet have been unable to obtain such speedy recoveries in these cases. These, then, are some of the reasons, at least, that have led me to abandon, in part, the older modes of treatment, and to select instead a more recent method, to which I desire to direct your attention at the present time. The whole question hinges upon one point—whether we can or can not reach the spores? If we can reach the organisms, then the agent that proves most effectual in their destruction is the one that should be selected. It is in consideration of this phase of the subject that galvanism forces its claims upon us. The science of electro-physics has long since made us familiar with the law that fluids in a galvanic current move from the positive to the negative pole. It has also long been known that the absorption of medicinal substances is hastened under the influence of the positive electrode of a galvanic battery placed upon the skin, and the negative electrode at some other point of the body to complete the circuit. This process may be called the law, or principle, of anodal diffusion, and is directly counter to another principle known as cathodal resistance, which is utilized when we wish to operate by electrolysis. The method, then, consists in applying the positive electrode, moistened with whatever parasiticide solution we may have selected, directly to the diseased surface, while the negative electrode is in contact with some other part of the body. While this is the usual mode of procedure, yet I have good reasons to believe that the simple passage of the electric current, without the presence of the parasiticide, is destructive at least to some species of these organisms. In carrying out this mode of treatment any of the standard batteries can be used.

The McIntosh or Storer answers every purpose. One thing to be remembered, however, is this: that a battery having a large number of small cells is more efficient than one having a small number of large cells, owing to the fact that the volume of the current is proportioned to the area of chemical activity. The extent of the chemical action is determined by the area of the surface exposed to the action of the exciting fluid. Another requisite is the milliamperemeter. This is an indispensable adjunct in carrying out the exact and scientific applications of galvanic electricity. We should be very particular as regards dosage in using the electric current for therapeutic purposes. As a rule, fifteen to twenty milliamperes is a sufficient strength of current when treating the class of diseases under consideration. Much also depends upon the dis-

tance between the poles, the size of the electrodes, and the sensibility of the parts operated upon. The length of time that the current should be kept up at each séance is also important. While no arbitrary rules can be laid down here, yet in the majority of cases the current should be kept up not less than ten minutes or more than twenty. The applications should never cause the patient any marked discomfort, as the efficiency of galvanism in these cases does not depend upon the intensity or resistance of the current. As regards the strength of the parasiticide solution, I am inclined to think that 1-to-1,000 or 1-to-500 bichloride solution is strong enough, although those who have used this method of treatment advise a one-per-cent. solution. We need not confine ourselves to bichloride of mercury, since any of the well-known parasiticides in aqueous, alcoholic, or ethereal solution can be used equally well. The positive electrode should be moistened in whatever solution we prefer at intervals of two or three minutes until the conclusion of the séance. When a large surface is to be treated, the electrode should be held upon a localized spot for several minutes, then lifted away, and placed upon another locality. Never use the labile current, or, in other words, never glide the electrode from place to place. The whole diseased surface should be gone over at each sitting. Finally, the patient should receive the treatment every day. At some future time I hope to be able to report a larger number of cases successfully treated with galvanism than I am at present able to do. Four cases have come under observation since this mode of treatment became familiar to me, all of which were brought to a speedy and successful issue.

CASE I.—*Tinea favosa* in a boy fourteen years old. Diseased surface has the characteristic yellow, sulphur-colored, brittle, umbilicated crusts, accompanied by the peculiar mouse-like odor. Location, posterior and right side of scalp. Diseased surface three inches in diameter when first seen. Disease of eight months' standing. First saw patient, March 1, 1889; last saw him, April 17, 1889, three weeks after last treatment. Complete recovery. Number of séances, six.

CASE II.—*Tinea circinata*, located upon forearm. Diseased surface as large as dollar coin. Two months' standing. First saw patient, March 5, 1889; last saw her, April 10, 1889. Complete recovery. Number of sittings, four.

CASE III.—Sister of patient No. 2. *Tinea circinata*. Location, left side of neck. Diseased surface circinate, as large as dollar coin. First saw patient, March 6, 1889; last saw her, April 10, 1889. Complete recovery. Number of séances, six.

CASE IV.—Little boy. *Tinea tonsurans*, three months' standing. Location, left parietal region. First saw patient, April 2, 1889; last saw him, April 30, 1889. Complete recovery. Number of séances, ten.

In all of these cases the diagnosis was verified with the microscope. It is very important to practice thorough cleanliness upon these patients,

together with epilation when the hairy parts are involved. This should be done before the regular treatment is instituted. The literature upon this subject is as yet quite meager, although, through the courtesy of Dr. Henry J. Reynolds, of Chicago, who is the originator of this mode of treatment, I have been enabled to learn that galvanism has been successfully used upon eight cases of tinea tonsurans treated in Belgium. Dr. Reynolds has also reported three successful cases in a paper read before the ninth International Medical Congress, and also several cases of tinea tonsurans in a paper read before the last meeting of the American Medical Association. That this method is very valuable in the treatment of parasitic skin diseases of vegetable origin there is no longer any doubt, and yet, like all other methods, the success depends upon the careful attention to details and the prevention of re-infection and auto-infection while the patient is under treatment.

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## Society Transactions.

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### THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

THIRD annual meeting, held at Newport, May 21 and 22, 1889.

#### OFFICIAL REPORT.

**The Question of the Radical Cure of Deep Urethral Stricture.**—DR. EDWARD L. KEYES, of New York, opened the session by reading a paper with this title, in which he confined his remarks to organic stricture situated at or beyond the bulbo-membranous junction. Strictures in the pendulous urethra had been demonstrated to be capable of radical cure, chiefly by the efforts of Professor Otis, while for the deep urethra no one was in a position to say what, if any, operation would radically cure strictures in this locality.

He defined three varieties of stricture clinically encountered in the deep urethra: First, the *soft stricture*, which was a superficial organic lesion involving only the surface of the mucosa. Such a stricture would often not admit a filiform bougie, yet a blunt steel sound of ordinary size might pass in many cases. It was generally situated at the bulbo-membranous junction, and was commonly accompanied by a moderate gleet as one of its symptoms.

Second, the *purely fibrous cicatricial stricture* was the traumatic stricture as found in the urethra previously unaffected by gonorrhœa. It might involve only the thickness of the mucous membrane, or include all the thickness of the perinæum and the integument. The fibrous stricture was linear or annular, but clearly defined.

The third variety was the *inodular stricture*, which might exist after traumatism, notably in a strumous subject and where there had been consid-

erable suppuration, perhaps burrowing abscess and multiple fistulae. It was lumpy, irregular, ill-defined, tortuous—never linear.

*Does dilatation ever radically cure deep urethral stricture?* Dr. Keyes concluded, from cases which had occurred in his practice, that dilatation might cure cases of *soft* stricture, but not the fibrous or the inodular stricture.

In reply to the question, *Did electrolysis ever cure deep urethral stricture?* Dr. Keyes held the same negative opinion as expressed in his paper read before the last meeting of this association in Washington. It was probable that the dilatation produced by the electrolytic instruments caused what improvement there was in strictures so treated. He thought that a pure fibrous stricture might be cured by *perineal section*, but that an inodular stricture usually was not.

Excision of stricture and transplantation of mucous membrane derived from an outside source seemed to offer more chance of radically curing inodular stricture than any other means we now possessed. This operation had been performed by Heusner with an apparent permanent cure at the end of one year. Three patients had been operated upon by Wölfler, of Gratz, in two of whom the result was satisfactory after a year's time.

DR. ALEX. W. STEIN, of New York, presented a paper on

**Some Aphorisms on the Treatment of Urethral Stricture.**—1. That gradual dilatation is unquestionably the safest method of treating urethral stricture. Aside from hemorrhages, abscesses, urinary infiltration, curvature of penis during erection, sloughing of tissue, etc., not unusual concomitants of internal urethrotomy, rigors and urethral fever are also exceptional phenomena in gradual dilatation. Most strictures yield to this method promptly and satisfactorily.

2. The objection usually made to gradual dilatation is that often the patient comes from a distance and seeks speedy relief. To this comes the obvious reply that we can not assume risks to the life of our patient in order to save time. But if time is an item, we know what continuous dilatation can do if he will confine himself to the house for a few days.

3. A urethra that is accustomed to instrumental manipulation will tolerate incision better than one that is not so accustomed. Should internal urethrotomy be decided upon, our patient is all the better prepared for having submitted to the obtunding effect which the passage of the instruments occasions.

4. In the pendulous portion of the urethra strictures are often so unyielding and resilient that dilating instruments have little or no effect upon them, and it may be said that the nearer such coarctations are to the meatus, the more do they partake of this character.

Such strictures are only amenable to dilating urethrotomy. But it must be said that while it is exceptional to have rigors with an elevation of temperature follow incisions near the meatus—

5. Other things being equal, the danger of internal urethrotomy increases with the depth of the stricture, that is, the distance the coarctation is from the meatus. The bulbous portion of the urethra is, from its anatomical nature, the most dilatable, and experience teaches that the nearer the stricture is to the bulb (not traumatic), the more it is amenable to dilatation. At least, not

until this has been fairly tried and has failed should incision of this portion of the canal be thought of, and then—

6. External division is to be preferred to the internal in all strictures requiring incision that are accessible from the perinæum (notably if of traumatic origin).

7. Slight encroachments upon the urethral caliber when submitted to internal urethrotomy are not, as a rule, attended with the same inconveniences that follow the operation upon narrow strictures, but strictures of large caliber rarely require cutting unless indeed a superficial contracting band occasions sufficient reflex disturbances to require prompt relief.

8. What has been said of internal urethrotomy applies with redoubled force to divulsion, with this addition: First, that it is unnecessary in the bulbous portion, and, secondly, that wherever employed it is dangerous, rude, inexact, and a purely mechanical means that does not exact and is exempt from surgical skill.

9. The term urethral fever has been objected to and urinary fever substituted on the assumption that the absorption of urinary constituents is the chief factor in the genesis of the complaint, but I do not think the choice of the substitute a happy one.

10. As to the ultimate results, thorough dilatation compares most favorably with urethrotomy.

It seems improbable that the absorption of urine can obtain in sufficient quantity from an epithelial abrasion produced by the passage of a sound that is capable of producing in rapid sequence rigors, fevers, suppression of urine, uræmic coma, and death.

**The Essential Factor in the Ætiology of Stricture and its Bearing on the Question of Radical Cure,\*** by DR. JOHN P. BRYSON, of St. Louis.—The foregoing papers were discussed together.

DR. WATSON said he had only one case to quote of a radical cure of deep urethral stricture. This was one upon which, nine years ago, Dr. Cheever operated for traumatic stricture by external perineal urethrotomy. He found a tough fibrous stricture extending from the bulbo-membranous junction backward at least half an inch. This was divided by a straight incision upon the floor of the urethra. Since then—for nine years—the patient had not been treated by the passage of any instrument. He examined him at the end of that time, and the stricture, which was left at 29 F., readily admitted a 27 F. sound.

Rapid healing was probably one of the elements favorable to the production of a radical cure. The more irritation the wound was subjected to during healing, the more likely we were to have a dense cicatrix, and consequently a less favorable result.

When possible, the division should be by one clean incision with a very sharp knife on the floor, and, if there was need, by a similar one upon the roof of the urethra.

DR. POST said that although many deep strictures were not cured by operation, still he was fully convinced that many were, and that even when fibrous

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\* Will be published in a subsequent number of this Journal.

or perhaps inodular in character. If internal urethrotomy sometimes produced a permanent cure, it was certainly rational to expect better results by external incision when we added to the sense of touch the aid of vision in guiding the operation. Syme reported such cures in cases carefully observed and faithfully recorded, in which he tested the urethra years after the operation. He considered that the requisites of a good external urethrotomy were a clean, straight incision of the stricture on the floor of the urethra, and also on the roof when the condition demanded it. All sinuses and irregular pockets or false passages should be slit up, and, when this was done thoroughly, quick and sound healing was likely to follow, with very little constitutional disturbance.

DR. CABOT said he liked Dr. Keyes's classification of strictures, and agreed with what had been said in regard to external urethrotomy and gradual dilatation. He thought that attention ought to be called to the usefulness of divulsion in the treatment of certain deep strictures. The cases to which he thought this method applicable lay between the first two divisions that Dr. Keyes made, and might be described as soft fibrous strictures. In two such cases he had had the opportunity of seeing the urethra three or four weeks after the operation. One patient died of suppurative peritonitis, starting from an old trouble about the gall-bladder; the other of Addison's disease, which was far advanced at the time the urethra was operated upon. In both cases the strictures were pretty tight and would not yield to dilatation. They both gave way readily to the divulsor and at once admitted the passage of sounds several sizes larger than the divulsing instrument, showing that the stricture had been broken and not merely stretched.

These urethrae, when examined post mortem, were found perfectly smooth, with no sign of a stricture or evidence of laceration, such as the opponents of divulsion claim is produced by the operation.

He regarded divulsion as an improper operation for tough fibrous strictures, which were only stretched, not broken, as well as for penile strictures, which were so much better treated by dilatation or internal urethrotomy.

DR. TAYLOR said that he thought the great majority of soft strictures could be cured by a slow intermitting course of gradual dilatation. This treatment took much time, and many patients would not faithfully follow it. When, however, it could be carried out, a permanent cure would result in many cases. After gradual dilatation, urethral fever was unlikely to occur. Even in case of penile stricture there were many that could be cured with a straight sound, aided by pressure and manipulation of the stricture over it. He expressed himself as strongly opposed to divulsion by the instruments of Holt, Thompson, or Vollemier. In the penile stricture, as a rule, Dr. Otis's operation would be preferable.

DR. WATSON said that he did not do urethrotomy in all penile strictures, as the patients would not submit to it. He thought the proportion in his operations would be one case of urethrotomy to ten treated by gradual dilatation. He had had, however, very few instances of anything even resembling a permanent cure after dilatation.

DR. KEYES did not think that urine leakage could be accepted as the only cause in the production of fibrous or inodular stricture. He instanced

meatotomy and lithotomy wounds as evidence that something more than mere contact with the urine was necessary to set up fibrous thickening of the parts. He was inclined to believe that the inodular stricture was generally occasioned by a tendency of the tissues to go astray, as in the strumous diathesis. In the scrofulo-syphilides the scar was inodular in character, that condition being due to tuberculous tendency. The gonorrhoeal poison, he thought, must have some similar influence upon tissues that were not strumous. In his opinion, the obstruction to the passage of urine which a stricture, even of good size, caused was sufficient to induce enough irritation to keep the tissues in a state of chronic thickening. Dilatation of the stricture in these cases relieved the tension in the canal behind it, and the hardening about the fistulæ disappeared. He agreed with Dr. Taylor as to the value of dilatation, and considered the operation of cutting as one of necessity to be used only in cases of exigency. He was sure that moderate strictures were cured by dilatation. The Otis divulsing urethrotome would not, he believed, effect a cure in the deep urethra; nor did he think the ordinary perineal section of the floor of the urethra would effect a radical cure. There was a possibility of cure of a fibrous stricture if cut entirely through on the roof and on the floor, in case it was not inodular. He wished to draw attention to the possibility that an inodular stricture might be cured by cutting out the diseased portion of urethra and putting in mucous membrane from somewhere else.

DR. BRYSON said that he did not disregard or undervalue the influence of tension in maintaining the stricture, but he did not think that tension alone would explain the indurated condition of urinary fistulæ. It was due, in his opinion, to the effort of the tissues to resist the entrance into them of the urine. The varying conditions of strictures he accounted for under similar influences by some individual quality of the tissues. The direction which the mechanical lesion took in the urethra, he thought, had much to do with the resulting stricturing process. In fact, internal urethrotomy was based upon the ground that a longitudinal cut in the urethra was not apt to result in any increased cicatricial formation. He thought that circular cuts could not heal without forming a stricture unless in some way the tissues were urine-tight. He believed that gradual dilatation sometimes cured deep urethral stricture. When strictures were cured by electrolysis, it was probably owing to the element of dilatation which it involved. Deep urethral strictures were sometimes cured by perineal section. He believed that excision of the strictured area should be resorted to, provided the cicatricial mass could not in any other way be covered by urine-tight mucous membrane. A better final result was, he thought, to be expected from urethroplasty than from section in those strictures that are not broad. Local treatment was of great benefit in bringing the mucous membrane back to its normal condition, and enabling it to resist the encroachment of the urine.

DR. STEIN expressed himself as strongly in favor of gradual dilatation when it would work, on account of its comparative freedom from danger. The mortality in internal urethrotomy of the penile urethra ranged from two per cent. to five per cent. He was opposed to divulsion, and regarded it a rough and brutal method.

DR. TAYLOR said that in cases where he wished to obtain a speedy cure he had cut strictures with a small Maisonneuve urethrotome up to No. 10 English, and had afterward used gradual dilatation for the further enlargement of the canal.

DR. BRYSON wished to be understood as heartily indorsing the method of dilatation in treating strictures. It was the ideal way and the one procedure that could not be eliminated from any method we adopted for the treatment of these lesions.

DR. POST showed a specimen from a patient upon whom internal urethrotomy had been done. The patient died fifteen days later of obstruction of the bowels caused by twist. The specimen showed a soft cicatricial splice in the floor of the urethra.

**Primary Syphilitic Lesions at the Meatus Urinarius.**\*—By DR. F. B. GREENOUGH, of Boston.

*Discussion.*

DR. POST said that the true chancre must be very much more frequent at the meatus than the chancreoid. In view of this and of the fact that the chancre in this position may be accompanied by very great inconvenience and disadvantage if allowed to proceed, he felt warranted in putting a patient with suspicious sore at the meatus upon constitutional treatment, tentatively at least, at a very early date. These lesions were difficult to diagnosticate, and frequently went unrecognized.

In regard to the use of the plug of cotton in the meatus, he was in favor of it; but he had occasionally seen cases in which it had proved to be an irritant rather than of assistance, and had been of necessity discontinued. He thought that meatotomy was often a source of aggravation in these cases, and was rarely called for.

DR. BRYSON said that he had seen many cases of stricture at the meatus the result of ulceration supposed to be chancreoid, and that he had found cases of this sort quite as hard to cure as those of stricture in the deeper parts of the canal.

DR. KING cited a case in which he cut a much-strictered meatus, and the extension of a chancre starting just behind it destroyed a considerable part of the glans penis. In this case constitutional symptoms confirmed the diagnosis.

DR. CABOT mentioned a case in which a very close and troublesome stricture at the meatus resulted from one of these ulcerations. An attempted operation upon it led to a very sharp attack of urethral fever.

DR. TAYLOR said that the chancres at the meatus had not been uncommon in his experience. Since last November he had had six cases of chancre and one of chancreoid in this situation. He regarded, however, the proportion of one chancreoid to six chancres as rather large. The development of these chancres was as follows: In the first place, an indurated mass, either unilateral or surrounding the urethra, without any excoriation whatever and with a bluish or purplish zone increasing along the glans and sometimes involving it all, so that the induration converted the glans into one hard mass;

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\* See page 248.



secondly, the surface superficially ulcerated, forming what is termed the "chancreous erosion"; third, that form of chancre which showed a creamy deposit upon its surface with more or less ulceration; fourth, only in case of a flaring meatus, an exuberance of syphilitic neoplasm forming larger or smaller masses. The course was very variable. Ulceration sometimes occurred owing to the changes of which Dr. Greenough spoke. In other cases healing took place by the absorption of the neoplasm, coincident to which there was a throwing out of fibrous tissue, resulting in a funnel-shaped stricture. Again, in several instances he had seen the whole indurated nodular mass, which seemed to be confined exactly to the walls of the spongy urethra which is in the glans, tunneled out as if bored with an auger, leaving after healing a stricture back of the glans with a pin-hole opening.

As to treatment, the cotton plugs with mercurial ointment that Dr. Greenough recommended were, as a rule, excellent. In private practice he had used little one-and-a-half-inch bougies, of about No. 10 or 12 French gauge, of mercurial ointment hardened with wax. These were inserted; a bird's nest of cotton was put over the orifice of the penis, then some gauze over that, and adhesive plaster over the gauze to keep it on. There were some cases, however, in which the mercurial ointment was extremely irritating. In those he had used bougies of iodoform (drachm to the ounce), always with the very best results.

DR. GREENOUGH said that he agreed with Dr. Post in regard to the extreme rarity of chancroidal ulcers at the meatus. The mere fact of a lesion being at the meatus would make him feel that the chances were very great of its being a true chancre.

He had found the plug with mercurial ointment useful in most cases, though sometimes it was not well borne. He regarded meatotomy as a measure only to be used as a last resort, as, for instance, in complete retention from an induration at the meatus.

**Induration of Venereal Sores not always an Indication that Constitutional Syphilis will Follow.\***—By DR. E. C. BURNETT, of St. Louis.

*Discussion.*

DR. POST said that venereal sores might occur in which there was no induration and which proved to be syphilitic, and that, on the other hand, indurated sores were seen which disappeared without further evidence of syphilis. These latter seemed to be cases in which the induration was due to some accidental origin, often uncleanness. He would prefer to draw the inference from these cases that induration sometimes occurred in non-syphilitic sores.

DR. GREENOUGH said that, in accordance with our former teaching, such cases admitted of two explanations: (a) that the sore itself was not a true syphilitic one, although simulating it as far as the induration and the glandular reaction went; or (b) that the secondary symptoms, when manifested, were so slight as not to be recognized. He had seen a syphilitic roseola that lasted only a very few days, and that might easily have been developed and faded out again between the intervals of ordinary visits.

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\* Will be published in a subsequent number of this Journal.

DR. KEYES said that the irregularities of syphilis were so great that it was a matter of surprise to see how many sores there were that fell into type, and how few, comparatively, were out of it. There were sores which no possible description and no possible discrimination of any ordinary powers of vision or intelligence could decide not to be typical primary lesions, and which were not followed by syphilis.

DR. TAYLOR said there was one pathological law that was invariable—that a syphilitic induration was a specific small-celled mass. This induration might be diffuse, and it might be difficult to distinguish from an inflammatory induration; but when treatment was adopted one usually found that the tendency of the syphilitic neoplasm was to contract itself into a hard mass of a bluish color, which, if compressed on the side, blanched, showing that it consisted of a sclerosed tissue. In his experience it was very rare to find any of this sclerosed tissue in non-syphilitic indurations, except that, in some cases of balanitis, when the swelling of the prepuce subsided, you would find hard submucous plaques as large as a three-cent piece or even larger.

DR. R. W. TAYLOR, of New York, in a paper on **Primary Melano-Sarcoma of the Vulva**, reported a case of primary melano-sarcoma of the vulva, which is one of the rarest forms of malignant new growth of these parts. The patient was sixty-two years of age, without history of cancer in the family or of injury or previous abnormality. At the age of sixty a slight smarting sensation and a bluish streak between the labia had been noticed, followed by a small, round tumor near the meatus, and later on a pea-sized tumor on the opposite side of the meatus. These were regarded as cancer, and excised by Dr. Trenholme in 1886. Two months later a bluish spot appeared to the right of the urethra and grew rapidly for two months, when this, too, was removed by operation. One month later another bluish wart-like tumor was observed on the right side of the meatus, and extended along the margin of the introitus vaginae. For eight months this growth increased in size, while a smaller growth made its appearance just above it. At this time the tumor had a bluish-black color, was perfectly smooth, homogeneous, and slightly shining on its surface, resembling a ripe plum, and measuring an inch and a half by an inch and a quarter.

The growth was firmly adherent to the mucous membrane; there were no inflammatory complications and no discharge. In the corresponding groin hyperplastic ganglia were matted together and firmly adherent to the deep fibrous tissue. The author removed the growth by cutting on June 16, 1887, and healing took place in twenty-four days. Hypodermic injections of Fowler's solution were given from the following October for two months, beginning with seven and ending with ten drops at a dose, and arsenic was then given by the mouth for a month. The patient died in July, 1888—thirteen months after the operation and three years after the invasion.

Six cases reported by other observers (all so far recorded) were given in detail and reviewed at some length. The histology, aetiology, and clinical history received careful consideration. So far as methods of treatment were concerned, the results were not brilliant or encouraging, but the patient should be given the benefit of the earliest and most thorough operation. The knife was regarded as preferable to destructive cauterization. If the ganglia

involved are movable and the mass not too old, they might be removed at the same time.

Hypodermics of arsenic certainly softened the mass of glands in this case and caused partial absorption, and if employed earlier might have proved curative. They should be administered in full and increasing doses as early and as long continued as possible.

#### *Discussion.*

DR. STEIN thought that melanosis was a disease by itself, and that the deposit of pigment in a malignant growth was accidental and did not stamp any particular characters upon such growth.

DR. GREENOUGH considered the presence of pigment in a carcinoma or sarcoma as a stamp of extreme malignancy.

DR. KEYES regarded the association of pigmentation with a soft tumor upon a mucous surface as a most virulent indication, and knew of no benign tumor, unless a mole were regarded as a tumor, in which we met with pigment.

DR. CABOT said that in the removal of these tumors there was practically no hope of a permanent cure. At the same time it seemed a wise plan to him to remove a comparatively wide zone of apparently healthy tissue with them. This precaution he thought especially indicated when the growth was small, and while there was still some hope that by an extensive operation the offshoots of the growth might be removed with it.

DR. TAYLOR, in answer to a question by Dr. Bryson, said that we occasionally saw melanoma of the pia mater, of the labia majora or minora, of the penis, and of other parts of the body in which the deposit of pigment was not associated with any tumor formation. More commonly, however, the pigment was associated with tumors of embryonal connective tissue (sarcomata) or with epithelial tumors (carcinomata). In connection with these pigmented tumors there was sometimes associated a considerable bronzing of the skin; and some observers stated that in these cases they had found blackish granules in the blood and in the urine.

**Treatment of Gonorrhœa and Gonorrhœal Cystitis.\***—By EDWARD R. PALMER, of Louisville, Ky.

**The Relation of the Prostate to Chronic Urethral Discharges.**—This contribution, by DR. J. WILLIAM WHITE, of Philadelphia, was read by the secretary.

The author referred to Ultzmann's views that the prostatic urethra was in reality the true neck of the bladder, which he would include between two sphincters—the internal at the vesical orifice, the external being the compressor urethræ. The latter he believed to resist more powerfully fluids injected from without, or the passage of urine or other liquids from within outward. He thought that discharges which appeared at the meatus were caused by inflammation somewhere in front of the triangular ligament, while those found in the urine were to be referred to inflammation posterior to that point.

DR. WHITE cited several authorities to show that several prostatic diseases

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\* Will be published in the August number of this Journal.

often produce a slight discharge at the meatus, showing that the compressor urethræ did not form an absolute barrier to discharges originating behind it.

The chief diagnostic points in a chronic gleet due to some affection of the prostate were the following: 1. Undue frequency of micturition, with pain felt at or near the end of the penis at the conclusion of the act. 2. The feeling of weight or fullness in the perinæum or rectum, especially during the passage of hardened fæces. 3. Diminution in the force of the stream of urine associated with dribbling toward the end of the act. 4. The first portion of urine passed would, if collected in a glass, contain more sediment than the second portion. 5. This sediment would be found to consist of prostatic epithelium, muco-pus, and a few shreds, often casts of the follicles and prostatic ducts. 6. A certain amount of sexual excitability, frequent erections, and premature ejaculations during attempts at intercourse were frequently associated with the before-described conditions. The author recommended, in addition to the usual methods of treatment, the employment of a jet of cold water directed against the perinæum twice daily—once after the evacuation of the bowels in the morning and again upon going to bed.

The patient should spend as much time as possible in the recumbent posture.

In discussing the paper, DR. BRYSON did not believe that simple congestion of the prostate gland with venous blood would account for the hypertrophic enlargement; for if a simple congestion would do that, we would have, he thought, more cases of hypertrophied prostate.

**Genito-urinary Notes\*** (*Serpiginous Chancroid of the Vagina, involving a Branch of the Anterior Trunk of the Internal Iliac Artery, the Sacro-sciatic Ligaments, etc.; Death from Hæmorrhage; Case of Hunterian Chancre in the Female*).—By DR. ALEXANDER W. STEIN, of New York.

DR. TAYLOR said that he had seen some pretty bad cases of serpiginous chancroid burrowing into the abdominal muscles and through them, causing fatal peritonitis. He had seen one which began on the fourchette, ate the perinæum away, and went up around the rectum, leaving a great hole so that the rectum would hang into the pelvic cavity about as one's hand hangs in the sleeve. In those cases only soft tissues were involved.

**Hereditary Syphilitic Transmission through Two Generations.**†—By DR. E. E. KING, of Toronto, Canada.

#### Discussion.

DR. BANGS said there might have been a source of syphilis which Dr. King had not discovered, and which, perhaps, might be impossible to discover.

DR. GREENOUGH said that Dr. King had undoubtedly established the fact of hereditary syphilis in the children; and it certainly looked as if the mother had been infected.

DR. POST said that, in order to establish heredity in the third generation, one must have not only a well-marked syphilis in the children, but also hereditary syphilis in the mother must be fully established, and in this case it

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\* See page 255.

† Will be published in a subsequent number of this Journal.

seemed to him there was a good deal wanting to establish hereditary syphilis in her case. The actual evidences of syphilis in her case appeared only after the birth of the children, and, as far as could be judged from description alone, they certainly corresponded much more definitely and fully to acquired than to hereditary syphilis.

DR. TAYLOR said that the verdict of "not proven" would have to be passed on all the cases from Hutchinson down of transmission to the third generation. None of them would stand close scrutiny. This might also be said of the cases in "*Syphilis, ses formes et son unité*," by Davasse.

In Dr. King's case we had a woman twenty-four years old breaking out with a secondary rash. In all the history of hereditary syphilis that he had ever read such a thing was unknown. When you reached the twenty-first year you got the gummatous ulcers, bone lesions, and recurrence of eye trouble, and perhaps more or less recurrence of earlier trouble. Here was a woman in the full plenitude of a secondary syphilis. He had never seen or heard of the case of a woman with hereditary syphilis at that stage presenting those lesions. In his judgment, if this woman had syphilis and did not get it from her husband, she acquired it somewhere else.

**Malignant Tumors of Inguinal Ganglia, Secondary to Epithelioma of the Penis.\***—By DR. R. W. TAYLOR, of New York.

#### *Discussion.*

DR. STEIN agreed with Dr. Taylor in regard to the importance of removing condylomata on account of the chance of their degenerating into carcinoma. He cited the case of a man in whom he had been able to observe this change.

DR. GREENOUGH also thought this point well taken; while not aware that the condylomata acuminata were liable to degenerate into epithelioma, still it would be but analogous to the cases of degeneration of ordinary warts on the face and about the nose into cancer, which is not uncommon.

DR. KEYES spoke of the variety of form of these epitheliomata, of the rapidity and virulence of the infection of the glands, and of the spread of the ulceration in some cases and of the very slow progress in other cases. He had seen epithelioma of the penis which lasted for years, and yet the man was a most magnificent specimen of robust and florid health.

There were some cases reported recently to have survived as late as six or seven years after thorough amputation of the penis. Abroad it was customary in many instances where epithelioma of the penis was removed to take out all the glands in each groin, and his impression was that that was the best procedure. He thought they were involved very early and before they could be felt, and were almost a certain source of recurrence of disease. No doubt any form of benign epithelial growth left in irritable surroundings was a source of danger when a man got along in life, and he thought it ought to be destroyed early.

*(To be continued.)*

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\* See page 241.

## Correspondence.

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**Difficulties of Diagnosis in a certain Eruption in Infants.**—Dr. Besnier showed, on the 14th of March, 1889, an infant which presented what at first view appeared to be a syphilitic eruption in the folds of the lower extremities. It is constituted at first by small vesicles, surrounded by a red areola resembling a herpes, or vaccination lesions. The vesicle collapses and disappears, and there persists a sort of elevated papule, with a depressed center, which seems like a syphilitic plaque. This is an affection which has been known at the St. Louis and at the Children's Hospital for some years as an eruption entirely distinct from syphilis, and to which has been given the name of *syphiloïdes post erosives infantiles* (Jacquet). In this case the lesions completely disappeared under the sole influence of bathing and powdered starch. The practical importance of these eruptions is considerable, as much from a therapeutic point of view as from a medico-legal standpoint. These *syphiloïdes* may be seen in healthy, robust children, but one of their great characteristics is that they are always limited to the lower extremities and to the natural folds of the limbs. There are other equally difficult syphiloïdes to diagnose, which are generalized, but they are for the most part observed among atrepsic children.

Thus Dr. Vidal (March 14, 1889) presented an infant six weeks of age who had excoriations about the cutaneous folds under the form of ulcerating erythema, and who further showed lesions upon the palms, and about the orifices of the mouth and of the nose, but there was neither coryza nor tumefaction of the liver, and, as improvement took place under simple baths and powdering with starch, it was thought that we had to do simply with a variety of seborrhoeal eczema. Another infant, shown at the same meeting by the same dermatologist with impetiginous lesions of the face, coryza, lesions of the palms of the hand and soles of the feet, but without tumefaction of the liver or anal mucous patches, was equally regarded after discussion as a non-syphilitic child, but only suffering from an unusual form of seborrhoeal eczema.

**Prognosis in Syphilitic Chancre.**—Apropos of an ulcerating chancre of the upper lip, Professor Fournier spoke of the prognosis of the ulterior syphilis from the aspect of the initial lesion. He regarded it as one of the most difficult questions to answer. In general there is certain connection between the character of the chancre and the first secondary manifestations. A chancre clearly ulcerating, deep, and leaving behind an extensive cicatrix, speaks for early secondary manifestations as a general thing, not of the nature of a roseola, but rather of a papillary syphilide, a papulo-tuberculous or even a tuberculous or slightly ulcerating lesion. There are, however, numerous exceptions to this rule; nevertheless, we must remember that the ulcerating chancre is generally followed by a syphilide of an important rather than of a grave nature. Dr. Besnier insists upon the difference in the prognosis, ac-

cording as the chancre is genital or extra-genital. If the chancre is extra-genital and presents in addition an enormous hypertrophy or an important ulceration, we can say with almost certainty that it is always followed by very intense secondary manifestations.

**Simple Chancres indurated by Contact of Urine.**—Professor Fournier presented (December 13, 1888) a patient showing several chancres of the prepuce which have the objective aspect of simple chancres but which to the touch are indurated; beneath them is felt a veritable indurated nodule. In the groins there is no adenopathy, and inoculation upon the arm had a positive result. The induration which accompanies the sores is of an irritative origin; in fact, the patient urinates upon the lesions and bathes them in the urine, which he considers an excellent remedy. Fournier insists upon the practical importance of these cases. The simple chancre is often indurated, and this induration alone can not be considered as demonstrative of the existence of syphilis. The agents of this induration are multiple, and embrace all sources of irritation, such as dirty dressings, excessive cautery, but especially incessant contact with urine.

**Alcoholic Syphilis.**—The same observer presented a woman on February 28, 1889, who demonstrated what he had often taught in his clinics, the gravity of syphilis in alcoholics. The patient was a young servant in a brewery who was in the habit of drinking thirty glasses of beer in the day, besides five or six kummels, twenty small brandies, and four or five absinthes. She entered the hospital with a recent syphilis of which she still shows the primary lesion upon the genitals not yet healed, and at the same time she has already upon the whole body a multiple generalized syphilide. These are papular, pustulo-crustaceous, and papulo-ulcerating. She suffers from insomnia, cephalalgia, and nerve disturbances. Upon the breasts and backs of the feet and hands are plaques of analgesia.

**Syphilitic Cephalalgias.**—Apropos of a patient presenting a syphilitic alopecia and an intense syphilitic cephalalgia following a chancre of the upper lip, Dr. Quinquaud (December 27, 1888) calls attention to headaches caused by syphilis; according to this observer, they are numerous and must be categorized. In his patient the cephalalgia represents the type neuralgia of the trigeminus. This neuralgiaform type presents some peculiarities from a therapeutic point of view. Sometimes it gives way to the iodide of potassium, but most frequently it resists this drug, and then it may disappear under the influence of two other drugs—atropine and tincture of gelsemium. Dr. Fournier says that for a long time he has endeavored to categorize syphilitic headaches. Besides the neuralgic pains and those of bone origin, there is to be found in the secondary period a cephalalgia which he calls neurasthenic cephalalgia of syphilitics. In fact, in syphilis nervous developments are found quite frequently in women, hysteria in particular, and that condition which goes by the name of neurasthenia. Among the troubles which come from the neurasthenia are found cephalalgia, which is of a particularly rebellious nature; it persists for months and appears to be especially benefited by treatment with mercury and cold douches. At a more advanced period of the syphilis we may equally observe another cephalalgia—that of tabes, which should be called preataxic cephalalgia.

**Chancre-like Indurated Tertiary Syphilis.**—Professor Fournier (March 7, 1889) presented a patient with this affection, which is quite frequently seen at the St. Louis Hospital. It occurs upon the genitals and particularly about the glando-preputial corona, and can simulate almost exactly the initial lesion of syphilis. It can be distinguished, however, in most cases by its base, which is more depressed and surrounded by a sort of hem. It differs further from simple chancre secondarily indurated in that it has not the alveolar base of the latter lesion. Professor Fournier insists upon the importance of the chancreform syphilides of the penis, as they are for the most part the lesions upon which published cases of reinfection of syphilis are based. He believes that syphilis is never seen a second time in the same individual. Dr. Besnier remarked that for the past fifteen years that he has made observations at the St. Louis Hospital he has never seen an authentic case of double syphilis. He believes that these lesions have also been confounded with epithelioma, and he relates in this connection the case under his own personal observation in which he came near causing the removal by surgical means of one of these lesions under consideration.

They develop, as a rule, at the point where the original chancre has been, a circumstance which seems to give some weight to the belief of those who hold that, for these lesions to appear, there must have been for a lengthened period a morbid germ hidden in the tissues at this point—a germ which remains in the latent condition for a time and then enters into activity without our knowing at the present time just why. However it may be, these syphilides of a chancre form always begin as slight interstitial nodes; they are in reality, then, only little gummata of the glands open at the exterior.

PARIS.

DR. L. BROCCQ.

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## Book Reviews.

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*Diseases of the Skin; their Description, Pathology, Diagnosis, and Treatment.* By H. RADCLIFFE CROCKER, M. D., Fellow of the Royal College of Physicians, London; Physician to the Skin Department, University College Hospital, etc. With Seventy-six Illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street, 1888.

SOME time since we took occasion to advert to the recent phenomenal growth of dermatological literature. Within the past two years no fewer than seven more or less complete and systematic treatises on diseases of the skin have appeared in English, all of which constitute valuable acquisitions to its standard literature. These numerous contributions attest no less the activity of the workers in this department than the growing interest and importance which this comparatively new specialty has assumed in the estimation of the profession.

The author has endeavored to embody in the work before us a succinct statement of our present knowledge of dermatology, which should serve as a reference to the general practitioner as well as a working manual for the stu-



dent. No one familiar with Dr. Crocker's ability and clinical opportunities will question his eminent fitness and thorough equipment for this task, in the accomplishment of which he has brought to bear the matured results of his twelve years' experience in the Skin Department of the University College Hospital of London.

While the work before us necessarily contains much that will be found in other standard treatises on diseases of the skin, yet in the admirable arrangement of the material, the rejection of useless details, the clear and concise modes of expression, and a certain original but forcible method of treating the various subjects, he has produced a book which, while embracing all essential facts relating to skin diseases, bears upon every page the impress of the author's independent thought and observation. But while the work is largely a reflex of the author's individual views and experience, he has not neglected to draw upon the observations and researches of other workers in the same field, the results of which are digested and presented in an available form. Numerous references are made to recent dermatological literature for more extended information upon subjects which can not be exhaustively treated in the necessarily restricted limits of a text-book. While especial prominence is given to the consideration of the diseases most prevalent in Europe and this country, tropical and endemic diseases are more fully treated of than is usual in works of this class.

After a careful examination of Dr. Crocker's book we have no hesitation in pronouncing it the best and most creditable exposition of the principles and practice of the modern school of British dermatology that has yet appeared.

The book is printed in clear, readable type, upon paper of superior quality, and the illustrations are for the most part admirably executed.

*Wood's Medical and Surgical Monographs.* Consisting of original treatises and of complete reproductions in English of books and monographs selected from the latest literature of foreign countries, with all illustrations, etc. Published monthly.

THE issue of the June number, containing Dr. August Schreiber's treatise on "General Orthopædics, including Surgical Operations," completes the second volume of this excellent series of monographs for the present year. Under the heading of "Books and Journals Received" we have already noticed the titles of the different subjects embraced in the previous numbers.

Although this series of publications is designed for the general practitioner, the numbers thus far issued contain much material of interest and value to the dermatologist and genito-urinary specialist.

The first volume opens with a collection of the admirable lectures of Mr. Jonathan Hutchinson, of London, on the "Pedigree of Disease." In considering the pathogenetic influence of heredity, diathesis, dyscrasia, etc., the illustrations are largely drawn from cutaneous diseases, with which the distinguished author is so thoroughly familiar. Syphilis, scrofula, lupus, eczema, psoriasis, etc., furnish examples in which the action of these ætiological agencies is distinctly traceable. In endeavoring to appreciate the nature of that ætiological mystery—idiosyncrasy—he finds the most favorable field for its

study in the incidental effects of drugs upon the skin. In the production of many forms of drug eruptions the influence of this factor is incontestable, and the production of these phenomena is otherwise inexplicable.

In the same number is found a reproduction of the manual of Dr. Robert M. Simon on "Common Diseases of the Skin," in which category are classed eczema, psoriasis, scabies, acne, and ringworm. These diseases are considered from a practical standpoint, especial prominence being given to their diagnosis and treatment.

The monograph on "Gonorrhœal Infection in Women," by Dr. William Japp Sinclair, contained in the second number, has already been favorably noticed in the April issue of this Journal.

In the first number of the second volume will be found a translation of the excellent treatise on "Blennorrhœa of the Sexual Organs" by Dr. Ernest Finger. A criticism might be passed upon substitution of the term blennorrhœa for gonorrhœa. While the use of the former may be justified as more correctly expressing the pathological condition present, yet the latter term has always been sanctioned by medical usage in this country. In reviewing the German edition of Dr. Finger's work upon its first appearance some months ago, attention was called to the comparatively small space devoted to gonorrhœal infection of the female sexual organs. This subject is so exhaustively treated in Dr. Sinclair's monograph that the one will form a fitting complement to the other.

The entire series of monographs thus far reproduced have been most judiciously selected. In no other publication will be found such an amount of fresh, standard literature, covering such a wide range of subjects and sufficiently diversified to meet the wants of the general practitioner as well as of the specialist in various departments.

*Electricity and the Methods of its Employment in removing Superfluous Hairs and other Facial Blemishes.* By PLYM S. HAYES, A. M., M. D., Professor of Analytical Chemistry, Chicago College of Pharmacy; Professor of Gynæcology and of Electro-therapeutics, Chicago Polyclinic, etc. Chicago: W. T. Keener, 96 Washington Street, 1889.

THE above title fully expresses the character and scope of this little work, which "has been written with the idea of answering the many questions asked by brother physicians relative to this subject, and of furnishing instruction to those who desire to become proficient in this operation."

The value of electrolysis in the removal of superfluous hair and its superiority to other methods have been of such comparatively recent demonstration that the operation is mentioned only in the latest text-books on skin diseases. The author of this monograph describes in detail the necessary apparatus to be employed, the dosage of the electricity, and the technique of the method, with the indications and contra-indications for its use.

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## Selections.

### Vaccinal Syphilis.

PROFESSOR FOURNIER has recently collected his lectures upon this subject and published them in a little volume. The number of instances cited to demonstrate the danger of vaccination from humanized virus is so great that it is a matter of wonder that so many physicians still practice other than animal vaccination. The epidemics of Cremona, in which forty infants out of forty-six vaccinated were infected with syphilis, and, secondarily, a certain number of their mothers and nurses; of Morbihan, in 1866, where forty-five children were infected; and other smaller outbreaks of a similar nature—are mentioned.

When syphilis has been inoculated along with vaccine virus, three alternatives may present themselves. Either syphilis is not transmitted, and, fortunately, this is the most frequent result; or the vaccination does not take, but syphilis is produced, and the symptoms and course are identical with those where the syphilitic virus alone is introduced into the body; or, finally, both forms of virus give a positive result, some points of insertion being followed by pure vaccine lesions, while the chancre appears only at the points where the vaccine has failed. Vaccinal syphilis always has an initial lesion, and this point must be remembered, so as not to mistake hereditary syphilis appearing shortly after vaccination for syphilis produced by vaccination.

It does not by any means follow that the child from whom the virus is taken must be in an active stage of syphilis in order to transmit the disease in this way. The syphilis may be latent, or the child may even be in course of inoculation with syphilis, as proved by cases seen in epidemics. A healthy child is inoculated, and on the seventh or eighth day serves as vaccinifer, and the virus he furnishes may inoculate syphilis, and this before the chancre has appeared in his own person. A common error is still made to believe that the danger of vaccinal syphilis resides in the blood alone. Liquid without perceptible color has in well-authenticated cases transmitted syphilis, but, without the aid of the microscope, it is impossible to say whether this colorless liquid contains blood elements or not. All colored vaccine virus should be rejected.

In the matter of diagnosis, ulcerating vaccinia must not be confounded with chancre, which it often simulates; but chancre never produces so extensive ulceration, and is accompanied by indolent adenopathies. Again, ulcerating vaccinia appears from twelve to fifteen days after vaccination, while the chancre seldom appears before the end of three weeks, and never before fifteen days.

Vaccinal eruptions are at times mistaken for syphilides. They appear from the ninth to the fifteenth day after vaccination, while syphilides can not appear before nine or ten weeks after this time.

In vaccinating a number of children at once, the instrument should always be most carefully washed after each single vaccination. The only sure pro-

phylactic measure is to employ only animal vaccine.—*Journal de médecine*, April, 1889.

### **Folliculitis Præputialis et Paraurethralis Gonorrhœica.**

DR. KARL TOUTON, of Wiesbaden, writes in the "Archiv für Derm. u. Syph.," Heft i, 1889, on the affection which CEdmansson and others have called urethritis externa. The literature of affections of the accessory glands of the female genital organs due to gonorrhœa is quite rich, and cases are being constantly reported of inflammation of Bartholini's or the vulvo-vaginal glands. The mucous glands of the urethra are too not infrequently found diseased, and Guérin has called especial attention to the implication of crypts and follicles about the orifice of the urethra in women. In man, prostatitis and inflammation of Cowper's glands have been frequent themes for publications. The discovery of gonococci in the pus of these affections had yet to be made. Arning and Bumm have found gonococci in Bartholinitis. Gerheim believes that in prostatitis we may have to do with a mixed infection. Inflammation of Littre's glands is not infrequently to be made out by the touch through the male urethra. They empty themselves either into the urethra, and thus give rise to short exacerbations of gonorrhœa, with pus containing gonococci, or they cause periurethral abscesses. They also often become the seat of chronic gonorrhœa.

Though inflammation of the orifices about the external portion of the urethra is not so often found in men as in women, still CEdmansson found it in ten cases, three times affecting both sides and seven times on one side only. As a rule, they open in the neighborhood of the posterior commissure of the orifice, and more rarely in front or behind the border. They are situated in the urethral wall, and may be as much as a centimetre in length. The author has had an opportunity to carefully observe two cases of gonorrhœal infection of the follicles of the prepuce and of those about the male urethra, and has examined microscopically sections of extirpated follicles, which show the gonococci in the epithelial tissues just as Bumm has demonstrated them in the tissues in gonorrhœal conjunctivitis.

In all cases of inflammation of the small preputial and paraurethral crypts in the course of gonorrhœa the secretion from them should be carefully examined by itself for gonococci.

The diseased follicle should be incised and scraped out early to prevent reinfection of the urethra, infection of a woman in the absence of gonorrhœal discharge from the urethra, and to prevent formation of abscess or phlegmon. In the neighborhood of the meatus, Martineau injects into the follicle 1-to-500 sublimate solution.

### **A Case of Syphilitic Disease of the Vertebrae.**

E. LEYDEN ("Berliner klinische Wochenschrift," No. 21, 1889) relates an interesting and unique history of a patient affected with syphilitic disease of the vertebrae, of which the following is a brief abstract: The patient, a German, aged thirty-four years, acquired in 1872 an ulcer on the penis, followed by a bubo which was incised, and not followed by any noticeable secondary symptoms.

His present trouble began two years ago with pain and uneasy sensations in the back; they were experienced in the lower portion of the spinal column and were at first increased by exercise; later they were more intense in the reclining posture. One year later pain began in the left leg, rendering its movements difficult and somewhat painful; at this time also he was unable to stand erect, the body inclining toward the right and the head forward. He now consulted a physician, who diagnosed a disease of the vertebræ, and advised the reclining posture. He was unable to comply with the advice, but came to Berlin, where his disease received a variety of names and as many forms of treatment.

His disease became aggravated, the left leg being three months later almost paralyzed, while the right one, together with the entire right side, was extremely hyperæsthetic, followed, however, in a short time by a paresis of the right arm and leg. At this time he entered a hospital, where the diagnosis of myelo-meningitis was made and the disease treated by daily applications of ice to the back, electricity, and baths. The treatment, extending over some months, availed little.

In February, 1889, the patient was admitted to the Charité under the care of Professor Leyden, when his condition was found to be as follows: The left leg stiff, admitting only of the slightest voluntary movement, the right leg showing a less degree of paralysis; the right arm slightly paretic and hyperæsthetic.

The examination of the vertebræ revealed the following interesting condition: In the lower dorsal and upper lumbar regions an angular curvature, involving a number of the vertebræ, was distinctly visible; on pressure, the swelling was exquisitely painful. The condition of the lower extremities could be well explained by the vertebral disease. To account for the disturbances of the upper extremity, a spot of great tenderness was found over the upper dorsal vertebra, though no swelling was seen. A further examination revealed swelling of the left ankle, the right arm, and of both clavicular joints. The diagnosis of syphilis was made in consequence of the multiplicity of the joint affections and the exquisite tenderness over the spinal lesions. In spinal caries one would scarcely expect to see two separate regions involved, and at the same time a multiple involvement of other joints. The diagnosis of multiple syphilitic joint disease was confirmed in a happy manner by the treatment, for after eight days' use of the iodide of potassium, combined with mercurial inunctions, a decided improvement began which continued during eight or nine weeks' use of the remedies, until only a slight degree of weakness remained in the left leg. The patient, when presented before the society of the Charité physicians in April, 1889, was able to walk, and even run and jump, without pain.

The tenderness over the vertebral column had entirely disappeared, while the curvature in the lower dorsal region was scarcely noticeable.

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## Items.

**The Elimination of Iodide of Potassium after the Use of Large Doses.**—Ehlers gives in the "Hospitalstidende," 1889, No. 1, the results of his observations concerning the elimination of iodide of potassium after the ingestion of large doses. He made in all seventy quantitative examinations of the urine, and found, as an average of all his examinations, 82 per cent. of the ingested drug in the urine. When symptoms of iodism developed, the urine examination showed a diminished elimination of the drug, the iodism disappearing as its elimination increased.—*Monatshefte für praktische Dermatologie*, Band viii, No. 9.

**Injection Brou.**—The "Journal de pharmacie" publishes the following new formula for this injection:

℞ Opil.....	0.5
Catechu.....	0.5
Croci.....	1.0
Aq. bullient.....	200.0
Infunde, filtra et adde:	
Plumbi acetat.....	1.5
Zinc. sulph.....	3.0
Misce.	

**Confluent Variola treated by Salicylic Acid.**—Dr. Baudon writes to the "Bulletin général de thérapeutique," May 15, 1889, that Mrs. J. contracted small-pox after assisting in the burial of her two brothers who died of the disease. The eruption soon became confluent, and the following treatment was adopted:

1. Three times daily the face and body were covered with an ointment composed of ten grammes of salicylic acid in two hundred and twenty-five of vaseline.
2. Then powdered with ten grammes of salicylic acid in two hundred and twenty-five grammes of tale.
3. Three wafers of twenty-five centigrammes of quinine were given daily.
4. Borated gargles.
5. Milk *à discrétion*.

The patient complained of no pain and there was no odor from the body. After eight days the application was scraped from the face and the skin found soft, without crusts, and free from cicatrices. Recovery was rapid and no complications were noted.

**Syphilis following Tattooing.**—In the "British Medical Journal" of May 4, 1889, Surgeon Barker gives the notes of an outbreak of twelve cases of syphilis occurring in the soldiers of a regiment who had been tattooed by the same man. Upon finding this man and instituting an examination of his person, he was found to be the subject of secondary syphilis, the mucous membrane of the mouth being the seat of numerous mucous tubercles, and the soft and hard palate being ulcerated. The chest was covered with "psoriasis" and "lepra." He had had a suspicious sore upon the penis a year before. The primary lesions occurred along the lines of the tattooing process after an incubation varying from thirteen to eighty-seven days, and in three instances only were they single Hunterian chancre. Six showed two sores, two had three, and one four. In five instances the primary lesion is described as a rupial ulcer, having a limpet-shell-like crust which, on falling off, left a plain and not an excavated base. The secondary manifestations were marked in all the cases. Evidence elicited from the men showed that the needles did not appear clean, that the operator put them into his mouth, that he used his saliva upon the arm to be tattooed, and also in some cases mixed his colors with it.

# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### THE ESSENTIAL FACTOR IN THE ÆTIOLOGY OF STRICTURE, AND ITS BEARING UPON THE QUESTION OF RADICAL CURE.\*

BY JOHN P. BRYSON, M. D.,  
St. Louis.

A STUDY of the ætiology and pathogenesis of urethral stricture involves, at the outset, a repudiation of that definition which makes of it a mere mechanical narrowing of the canal, for any such definition includes conditions which no one regards as stricture in the true sense of that term. Polypi and warty growths springing from the urethral wall cause unnatural narrowings, and are not in any sense strictures. The same is to be said of collections of fluid in the peri-urethral spaces, and of tumors pressing upon the duct. An acute inflammation of the prostate gland certainly causes a lessening of the dilatability of that part of the urethra, yet it is universally conceded that stricture, as a disease, does not affect this part of the canal at all. It is only when one regards stricture as a pathological condition of the urethral wall and subjacent tissues that he is in a position to study, in a rational, scientific manner, the factors concerned in its inception and development. It is, therefore, of stricture as a disease, and not as a mere mechanical narrowing of the duct, that I would speak here.

If, now, we compare a stricture with one of those congenital narrowings not uncommonly met with in practice, and which is quite as much an unnatural narrowing of the canal, we easily note several differences both in structure and in pathological behavior. In the case of the

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\* Read, in the discussion of "The Question of the Radical Cure of Deep Urethral Stricture," before the American Association of Genito-urinary Surgeons at its third annual meeting, May 21, 1889.

stricture, we observe that it not only causes a narrowing of the duct, but that this constantly increases. In the case of congenital coarctation the canal is narrow, it is true, but that narrowing does not increase, but remains stationary. There is, then, an activity manifested by the former disease (stricture) which is totally absent in the latter condition (congenital narrowing). We observe, secondly, an anatomical difference, and it is one of great importance. In the case of the malformation, the point of narrowing is lined by normal and healthy mucous membrane, while the stricturing bands are overlaid by a mucous membrane, which is altered by inflammation or otherwise diseased, or is totally absent (cicatricial stricture). If, now, we apply the same treatment to the two cases, we will observe a corresponding difference in the result obtained. Division of the congenital narrowing is not followed by recontraction, while in the case of the stricture the disposition to recontraction is so marked and distinct that to prevent it really constitutes the surgical problem the solution of which would rob this formidable disease of its terrors for surgeon and patient.

One may say, then, that the definitive characteristic of stricture, as a disease, is the persistent tendency of its constituent elements to multiply, to become more dense, and to contract toward the axis of the affected canal. This would exclude congenital narrowings from the list of diseases, and leave them where they belong—among the obstructing conditions, they being malformations and lacking the essential element of activity.

In studying the pathogenesis of this disease we must also make a distinction between those conditions which permit the process to begin and to continue, and the stricture-building itself. An ulcer, for instance, is not a stricture, and can never become one while it remains an ulcer. It is when the ulcer heals, and the site is replaced by a cicatrix, that the pathological processes begin, the sum of which is stricture-building. In a word, it is the changed condition of the mucous membrane which permits the stricture-forming. Mere inflammation of the urethral mucous membrane, even in its chronic form, is not stricture, and it is only in certain cases that the urethral mucosa is so altered by it as to permit of that peri-urethral fibrous overgrowth which constitutes the disease we name stricture. Here, again, we have an altered condition of the mucous membrane preceding the stricture development. Any number of times we see both of these pathological processes (inflammation and ulceration) approaching, without involving the urethral mucous membrane, from another direction, and still no stricture-building is inaugurated. If, however, either of them, coming from whatever direction, reaches and modifies the mucosa, we seem invariably to see the inception of the stricture disease, provided always that this altered state remains for a sufficient length of time. The essential thing seems to be that the mucous membranes undergo some not



yet clearly defined change. This necessary thing being once accomplished, we have a steady and persistent growth of fibrous connective tissue underneath the affected portion of the membrane, pushing it more and more toward the axis on the one hand, and on the other involving in its meshes the underlying and adjacent spongy elements, causing their atrophic degeneration, and finally their total disappearance. Thus we see it is underneath the membrane that the pathological process is active; and even in those cases of cicatricial stricture, on the urethral side of which there is no mucous membrane whatever, it is in the peri-urethral tissues that development of new tissue goes on, the urethral side only undergoing a change marked by condensation. In other words, we have in all cases a chronic peri-urethritis, with a distinct tendency to contract toward the axis of the canal.

I would therefore propose the name of chronic contracting peri-urethritis by which to designate the stricture disease.

If we include under this designation all cases belonging there, we may at once eliminate the microbe as an essential factor in the aetiology. Certainly no one will accuse the traumatic cases of being microbial in origin or the microbe of having any essential pathogenetic relation to them. The researches of Oberländer and Neelson very clearly show the manner in which the microbe of gonorrhœa may, as it so frequently does, play the principal part in that modification of the mucous membrane which is apparently necessary to the inception and continuation of the disease. In fact, the disease gonorrhœa has long been known to hold this relation, the great majority of inflammatory strictures having followed it in such a way as to leave no room for doubt.

To an English surgeon is due the credit of making the most important contribution to our knowledge of the pathogenesis of chronic contracting peri-urethritis we have yet had. It was Mr. Reginald Harrison, of Liverpool, who showed that the chronic, persistent deposition of the so-called stricture-tissue was really a reaction of the underlying tissues against the leakage of urine or some of its numerous constituent elements through the altered mucous membrane; and this luminous demonstration not only adequately accounts for the different steps in the pathology of the disease, but it points the direction which radical treatment should take. Under this conception of the pathogenesis of the disease we have the changed condition of the mucosa, which permits of urine leakage as the essential though passive factor, and the leakage as the active element, rousing and maintaining the antagonism of the underlying tissues. This does away with the old mechanical one completely and adequately clears the field for treatment.

So long as the old mechanical conception held sway in the surgical mind it was but natural that a purely mechanical treatment should be

resorted to in order to conquer it. In a certain sense great benefit has resulted from this, for surgeons were stimulated to increased and never-ceasing efforts to devise new and better apparatus and technique. It was out of these efforts and the opportunities which they afforded for observation that our present admirable treatment known as "inflammatory atrophic dilatation" grew, and we have learned from our predecessors how to apply this method in a rational, scientific manner to the merely obstructive part of the disease. So well indeed has the mechanical side of the matter been met that it may be seriously questioned whether our present armamentarium will ever be improved upon in any essential particular, or whether there is need for such improvement. With the means at our present command and ordinary skill in their use, one can say that the mere obstruction to urination is, in the great majority of cases, capable of being easily, safely, and adequately overcome by the modern surgeon. Indeed, this does not constitute the difficulty any longer. Here, where we have under consideration the question of the radical cure, it is easily perceived that it is not a question of removal of the mechanical obstacle so much as it is one of permanency of result. It is that treatment which will forever prevent recontraction, or, in other words, which will inhibit the pathological changes whose activity constitutes the disease that chiefly concerns modern surgery, for in our day it is clearly recognized that here lies the danger to the patient.

I can not help thinking that something may be gained by observing the manner in which "that cunningest pattern of excellence, Nature," goes about treating this disease on her own account. If we watch a case which has not been interfered with surgically, we will observe the following course of events: As the narrowing progresses there is a gradual dilatation of the uninvolved urethra immediately behind the stricture. The walls of this dilated portion are rather in a state of atrophy than of inflammation, for we get mucus and necrotic epithelia from its surface rather than pus, and we observe that it is in a state of venous congestion. There are thinning and devitalization; finally, an erosion or an ulcer forms. These changes are apt to be greatest at that part immediately posterior to the deeper edge of the stricturing band and on the inferior wall of the duct. So low are the normal reparative energies that no bands are thrown out to re-enforce it. Finally, we have urinary infiltration, or lower down, where there is yet enough energy remaining, an abscess cavity forms, points at the surface of the body, bursts or is opened, and gives exit to the urine, forming a fistula; but at first this is a fistula with soft and yielding walls. Gradually energy is gained, the tissues begin to resist the urinary encroachments, and we have eventually a fistula with hard walls, this hardening being the result of the development of the same kind of tissue that in the beginning caused the urethral narrowing; and this tissue behaves in the same way—

namely, increases in bulk, condenses, and tends to contract upon the opening so long as urine is permitted to flow through the tract. How of the stricture-band in the mean time? At first, when the fistula has formed and has soft walls, there is no great obstruction offered by it, and all the urine passes through by the new channel; but, however wide the fistulous opening may be, some urine comes in contact with the posterior edge of the stricture, perhaps remains constantly in contact, and so there is the necessary condition for a continuation of the peri-urethral contraction of the stricture-band, and especially of its posterior edge. This answers to this stimulation just as the stricture did originally, and tightly seals the urethral outlet of the pouch, forcing the urine to pass by the new way. It takes time for hard walls to form about the fistula, and more time for them to contract to such a degree as to offer great resistance to the urine. When they do, we have what seems a battle between the urethral narrowing and the obstructive efforts on the part of the fistulous opening, and it is quite interesting to observe the successful way in which the peri-urethral bands hold their own even when they are, as often occurs, only a line or two in breadth, for they are often seen to keep the urethra tightly closed while forcing the formation of one, two, several new fistulous outlets, which latter have at first soft and yielding walls which offer a minimum of resistance.

There is one other phenomenon in this series of changes which is of interest as well as of practical value, and that is the behavior of the anterior portion of the stricturing band, off which all urine is kept. For a long time I have been in the habit of calling the attention of my assistants and others about me to the fact that, when I was operating upon a case of this kind, where for a long time all the urine had apparently passed by fistulous openings, and none by the urethra, we always had to deal, at the critical moment, with an extremely narrow stricturing ring, in many cases quite resembling a thin diaphragm, through which there was still a very small hole to pass a probe. And this was not all. In some of the cases it was apparent, on inserting the Avery's threads to hold asunder the parts, that there was a pouch, or rather an unnaturally dilatable condition of the urethral walls in front of the diaphragm-like coarctation, as well as behind it, but presenting a different appearance upon inspection after the section was made; for the walls of the anterior pouch were pale pink and healthy-looking, while those of the one posterior to the coarctation were soft, friable, covered by necrotic epithelium, and with veins deeply injected. For a long time this state of things puzzled me, as did the fact that I never found a broad stricture-band encircling and compressing the urethra in these cases. I am now persuaded that this condition is the result of the atrophy and disappearance of the anterior portion of what was once a broader stricture-band, without

reproduction of the normal elements, which had undergone shrinkage from pressure of the previously existing connective-tissue elements. Such a state of things might be expected to come about after the withdrawal of the outer supports of the mucous membrane. And I am all the more persuaded that this is the real explanation by watching the changes taking place in the walls of the fistulæ after the urine was made to pass by the natural way or was withdrawn through a catheter; for here we observe the atrophy and disappearance of the same kind of tissue as the stricturing bands, in a manner quite striking. This, in my observation, goes on quite as rapidly and satisfactorily in the cases of fistulæ that are not as in those that are attacked by the knife. The essential thing seems to be the removal of urine from contact.

Mr. Harrison ("Lettsonian Lectures," 1888, p. 14), in speaking of the intention manifested by the tissue development in stricture, says: "In this strengthening of the urethra we recognize, in the first instance, a conservative action; eventually, however, as in other compensating processes, certain inconveniences follow which constitute, as it were, an independent disease." With that part of this view which regards the development of the stricture-bands in support of the urine-tight state of the urethra as conservative I agree; but if I correctly interpret the author to mean that the effort of the process to close up the urethra is but an accidental and vicious one, or one not equally conservative, I must respectfully dissent from that view. To my thinking, the intent to close up the canal at the point of narrowing is manifest from the very beginning, and it would seem to be quite as conservative as any other of these phenomena. For, if the mucous membrane is no longer functionally efficient, it is manifest very soon that, develop and condense as it may, neither is the stricturing neoplasm capable of preventing entirely urinary resorption. If the effort was solely to strengthen the urethra against the urine, the tissue development might just as well be eccentric, whereas it is in an opposite direction, and with an evident intention. In a word, Nature seems early to have realized that the affected mucous membrane is best protected and cared for by being squeezed together tightly enough to keep urine off it altogether.

The rate at which this urethral narrowing goes on is another feature of practical importance as well as of theoretical interest. We all know that the stricture-building process is a distinctly chronic one, requiring months and even years in most cases to extensively interfere with the functions of the parts, and we can not help regarding this slow rate of progress as an important item of conservatism so far, at least, as the life of the affected individual is concerned, for it affords opportunity for the development of those changes in the tissues immediately posterior to the lesion in such a way as least to jeopardize other organs which may be necessarily affected.

It is only by this slow progress that the bladder, ureters, and kidneys are protected, even in a small way, by being allowed time for adjustment to the new order of things. One sees a different and far more dangerous condition arising in those rapidly developing cases of traumatic lesion where the passages may be shut up in a few hours by the mere swelling and distortion from laceration.

It is universally conceded that the pathological process concerned in the development of the stricture-bands is one of the forms of inflammation—contracting, non-suppurative inflammation. The modern pathology requires us to believe that we must have a factor at work which is in some degree commensurate with the duration of the disease, or, in other words, that the inflammation will exist only so long as the causative factor is present and efficient. Remove this ætiological factor and the process ceases at once, and at least and in many cases there is a retrogressive action in the newly formed elements which may and often does go on until they have totally disappeared. One of the methods of dealing with the purely obstructive part of the disease is to change the constructive into a suppurative inflammation. Atrophic, inflammatory dilatation of a stricture does this and nothing more. May we not accomplish the same retrogressive change by simply removing the factor concerned in the development of the newly formed tissues? I believe we can, not perhaps as rapidly as is required in many cases; but one is hardly permitted to doubt that it can be done when he watches the rapid and complete retrogression which takes place in the hardened walls of an old urinary fistula after he has removed the urine from contact. If we could, in the case of inflammatory stricture where we still have mucous membrane left, restore that membrane to its normal condition in every respect, we would, I think, be able to cure the disease permanently without either dilatation, cutting, or splitting, and the cure or restoration of the normal state of the parts would in every respect resemble the changes we observe in the fistulous walls after diverting the urinary stream; and it would be just as permanent or radical. If, however, we should fail in this because of the development of a cicatricial mass incapable of absorption, we would at least arrest the process of stricture-building. In the case of cicatricial stricture we could accomplish a like result by covering the altered portion of the urethral wall with healthy normal mucous membrane (transplantation, urethroplasty), though not here to the same extent might the caliber of the canal be raised. We would rather in this instance bring about a state of things closely resembling those non-progressive and far less dangerous states known to us as congenital narrowings. We would then have malformation, but not stricture in the sense here intended.

I conclude, then :

1. That the essential ætiological factor in urethral stricture is a modi-

fication of the mucous membrane in such a way as to permit of the leakage of urine or of some of its constituents.

2. That the surgical indications thus afforded are (*a*) to restore the mucous membrane to its normal condition, if that be possible, as it often is in inflammatory stricture; or, (*b*) failing in all efforts to restore the membrane, to remove the urine from contact by providing an artificial channel for its escape.

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A CASE OF SCIRRHOUS CANCER OF THE BLADDER IN WHICH  
VILLI WERE NOT FOUND IN THE URINE, AND A CASE  
OF CYSTITIS, WITH ULCERATION, IN WHICH  
VILLI WERE FOUND IN THE URINE,  
ALTHOUGH NO TUMOR EXISTED.\*

By ARTHUR T. CABOT, A. M., M. D.

**T**HE first patient was a man of fifty-five. The duration of his illness from the appearance of the first symptoms to death was about two and a half years.

The history was briefly as follows:

Two years and a half ago, after a long ride on horseback, he had quite a sharp hæmaturia, of short duration. Soon after this he began to notice frequency of micturition, which was presently associated with pain. His pain was of two kinds: One, a dull, persistent pain, felt just above the pubes and sometimes to the left, sometimes to the right of the median line. The other pain was sharper in character, was felt along the urethra and through the penis, and was aggravated by micturition.

After the first hæmorrhage there were several similar attacks of bleeding occurring at considerable intervals, and the severity of the pain and the frequency of micturition, though somewhat intermittent, increased pretty steadily in spite of all measures for their relief.

In March, 1888, Dr. John Homans, who saw the patient in consultation with his medical attendant, touched a stone and gave ether, intending to remove it by litholapaxy; but he was unable to grasp anything with the lithotrite, and the washing brought away only a little calcareous matter.

This operation was followed for a few days by some relief of the pain.

Examination of the urine at this time showed nothing beyond a little mucus in the sediment, with many oxalate-of-lime crystals.

In July, 1888, I saw the patient for the first time. The symptoms had continued about the same since March, although he had during the interval steadily lost flesh and strength.

Careful examination of the urine detected nothing beyond a moderate amount of pus in the sediment.

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\* Read at the third annual meeting of the American Association of Genito-urinary Surgeons, May 22, 1889.

With the sound a stone could be felt which seemed to lie or be held in the upper part of the bladder, and was most easily found when the viscus was empty.

Abdominal palpation revealed nothing in the bladder or kidney, and by the rectum only a moderate symmetrical enlargement of the prostate was felt.

It was decided to again etherize the patient, and, if the stone still eluded the lithotrite, to do lithotomy.

Ether was given early in August, 1888, and with the lithotrite the stone was again felt in the top of the bladder, but could not be grasped.

The sensation imparted through the instrument was as if a calculus lay in a sac in the vesical wall, where it could not be reached with the blades of the lithotrite.

Owing to its position, it was thought that it could probably best be dealt with by suprapubic cystotomy, and the high incision was made after filling the bladder and distending the rectum with a rubber bag after the Garson-Petersen method.

Upon coming down upon the bladder, a hard mass about an inch and a half in transverse diameter was felt behind the pubes. It was at first thought that this was the encapsulated stone, but the knife thrust into it did not encounter a stone, nor did it open the bladder.

This thrust did open the peritonæum, although it was made close upon the upper edge of the pubes.

By separating the tissues laterally and further investigating the condition, it was found that the central tumor extended down behind the pubes as far as could be felt, and was surrounded by several smaller nodules, which, when punctured with a needle, gave no calcareous resistance. Further, it was found that the tissues about were adherent to and puckered into the tumor, which was evidently a malignant new growth.

The contracting character of this tumor, shown by the puckering of the tissues about into it, made the diagnosis of scirrhus cancer probable, and its extension deeply behind the pubes toward the prostate made it evident that the growth could not be removed with any reasonable hope of present safety to the patient. In view of this and of the practical certainty of its return, it was decided to desist from further interference. The peritoneal rent was closed with a fine, continuous silk suture, and the outer wound was brought together with interrupted sutures.

The patient made a good recovery from this operation. In the washings which were obtained from the bladder at this time, one bit was found which Dr. W. W. Gannett thought to be a piece of a new growth.

From this time the disease steadily progressed, with a good deal of pain and a gradually increasing frequency of micturition, which seemed to be due largely to a progressive diminution in the size of the bladder.

The patient finally died, April 17, 1889, with evidence of disease of the kidneys, which came on rapidly toward the end of life.

At the autopsy, pyelonephritis was found, together with the local condition which is shown in the specimen.

The bladder is reduced to a small size, and is attached to the pubes by a new growth which involves the whole anterior bladder wall and projects into the vesical cavity as an irregular papillomatous nodule, one portion of which is covered by a thick calcareous incrustation.

The tumor outside of the bladder forms one nodule about two inches in diameter, which has grown into the lower end of the rectus and pyramidalis muscle and encroaches somewhat upon the upper edge of the pubes.

Microscopical examination by Dr. W. F. Whitney has shown this to be a carcinoma with much contracting intercellular tissue. The anterior commissure of the prostate shows a similar carcinomatous change.

The specimen does not enable one to say whether the tumor had its origin in the bladder wall or whether it started in the prostate.

Klebs and some other observers think that cancer of the male bladder always starts in the prostate, and, although many exceptions to this rule have been reported, it is doubtless true that a large proportion of the cancers situated near the neck of the bladder are prostatic in their origin.

In this case clinical observation never showed any marked change in the prostate beyond a slight, even enlargement. The character of the growth was unusual among bladder tumors, and the difficulty of diagnosis, owing to the absence of villi in the urine, was of interest.

In connection with this observation the writer would like to briefly report another case of difficult diagnosis in which villi were present in the urine, although no tumor existed in the bladder :

The patient was an old man with an enlarged prostate and quite a severe cystitis. He was seen in consultation with Dr. Reed, of Dorchester, and was suffering much from the obstruction to micturition caused by the prostatic enlargement. A catheter was tied into the bladder to relieve the constant tenesmus which made rest impossible, and a specimen of the urine was examined by Dr. W. W. Gannett. It was a foul urine, containing blood and pus, with what appeared to be well-marked villi from a papillomatous growth.

The age of the patient made it seem probable that a cancerous growth existed in the bladder, and a perineal opening was advised. The family could not at first make up their minds to this, and when they finally sent for me the patient was moribund and no operation was deemed advisable. He died a few hours later.

A partial autopsy was made, and the following is Dr. Gannett's report on the condition of the bladder and prostate :

"The cavity of the bladder was enlarged and the wall was about three times the usual thickness. The trabeculae were fairly prominent. The mucous membrane in general was of a slaty color and quite opaque. Here and there in the trigonum were small areas covered with a fibrinous false membrane, which was firmly adherent.



"Each lateral lobe of the prostate was enlarged to the size of a big horse-chestnut, and the so-called middle lobe formed a pear-shaped body about the diameter and rather longer than a big olive. It measured from the colliculus seminalis to the posterior tip seven centimetres.

"There was a loss of mucous membrane upon portions of its upper surface, and also a few diphtheritic patches.

"The whole specimen was hardened, and vertical sections were made through various parts. In the middle lobe of the prostate the erosion had bared the gland structure and there was a proliferation of the glands in the form of long acini, lined by a single layer of epithelium. These, projecting into the ulcerated surface and separated from each other by a thin layer of fibrous tissue, gave the appearance of villi, and it was probably these that were found in the urine.

"No evidence of cancer was found in the prostate."

We had here a severe cystitis with erosion of the bladder surface of the prostate laying bare the proliferating gland acini, and, some of these becoming separated and being found in the urine, presented the appearance of villi from a papillomatous growth.

I do not remember to have seen this source of error in such cases mentioned, and it therefore seems to me important to put this report upon record.

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#### DERMATITIS MULTIFORMIS GESTATIONIS.

By CHARLES W. ALLEN, M. D.,  
Surgeon to Charity Hospital, etc.

ON April 18, 1889, I was asked by Dr. S. Barnett, of this city, to see with him a patient in childbed who had some severe skin affection.

Mrs. Mary N., native of England, twenty-six years of age, had been delivered, at term, one week before of a healthy-looking child. The history given was that her first pregnancy had resulted in the birth of a living healthy child five years ago, which had subsequently died of diphtheria, and that in the interval she had aborted six times without known cause, usually in the third or fourth month. She had never known of a syphilitic taint, had never had any eruption of any kind upon the skin, and, indeed, no evidences of syphilis were to be found upon the body or in her history, or in that of her husband, so far as obtainable.

One month before the date of her present confinement the "waters broke," and so much fluid was discharged that she thought she was again to have a miscarriage. This fact gave the patient great worryment and concern, for she was most anxious to bear a living child. One week before delivery and two weeks before I first saw her there had appeared a good-sized bulla just over the umbilicus, and in a half-circle above and to one side of this a num-

ber of small vesicles. This eruption had been preceded by several days at least of itching confined to this portion of the abdomen. Almost at the same time vesicles were noticed between the fingers, upon the toes, backs of the feet, and inner surface of the thighs.

These lesions were not at all troublesome, did not give rise to subjective symptoms, excepting a slight itching, and, as they showed little tendency to rupture, did not receive much attention. As soon as the child was born, however, the eruption became greatly aggravated. Erythematous patches, which were extremely itchy and had a disagreeable feeling, which patient says was neither a burning nor a pain, but was "nasty," appeared upon the anterior surfaces of the thighs, and within a few days became covered with small vesicles and moderately large bullæ, while the whole of the right arm from the shoulder to the wrist presented the appearance of a typical pemphigus vulgaris, the bullæ, without noticeable surrounding areola, arising from apparently healthy skin, not the seat of previous erythema. When I first saw the lady the right arm was found thickly studded with tense round and oval bullæ from the size of a pea to that of a small hen's egg. For the most parts the walls of the bleb were tense and the contents a citron-yellow fluid of slightly alkaline reaction. A few of the lesions which had first appeared had become confluent, ruptured, and the walls were either entirely gone or were lying upon the denuded areas in folds and shreds of whitened epithelium. The arm was very painful, and where the epidermis had been rubbed off was suggestive of a burn.

Groups of vesicles from the size of a pin's head to that of a pea were scattered over the thighs, especially upon the reddened patches already mentioned, which in places appeared as though made up of minute vesicles which had dried up, become red and flattened, and shining on their summits. Single frank vesicles and groups of two or three were also seen to arise from skin in every way normal in appearance. In the region of the ankles there were a number of round tense bullæ which had become pustular, and upon the chin there was a group of lentil-sized pustules (they had begun as vesicles) seated on an inflamed base. Upon the sole of the right foot was a cluster of deep-seated vesicles which had appeared on the preceding day. The back was entirely free from any signs of eruption, and remained so throughout. The mucous membranes were also exempt.

The patient's general condition was one of marked depression, despondency, and suffering. The tongue was flabby and thickly coated with a white fur. Diarrhoea and headache were present, the arm was very painful, and the temperature, which had been elevated since the onset, was now 102° in the axilla. The lochia had been very scanty. Treatment consisted in the application of the following paste so as to thickly cover all affected regions:

℞ Pulv. zinci oxidi,  
 Bismuthi subnit. .... ʒiij;  
 Amyli ..... ʒijss.;  
 Tinct. benzoini co. .... ʒss.;  
 Acidi carbolici. .... ʒss.;  
 Petrolati ..... q. s. ad ʒiv.

M. Ft. pastam.

Internally, Fowler's solution of arsenic was given three times daily, beginning with six minims, gradually decreasing a drop at each dose till a two-minim dose was reached, and then increasing in the same way up to eight minims.

April 19. New bullæ have appeared upon the inner aspects of the thighs, preceded by erythema and great itching. Bullæ the size of English walnuts have formed upon the posterior aspect of the right arm, and there is now a denuded patch as large as the palm. (The first crops were all upon the anterior surface.)

The left arm, which was yesterday entirely free from eruption, now shows its first crop of bean-sized, clear, round, tense bullæ. The flexor surface of this arm about the elbow and the regions above and below it are occupied by an extensive cicatrix, the result of a burn received in childhood. No lesions have as yet formed upon this cicatricial tissue. A single large bulla is located upon the upper lip. Those upon the chin are drying up and the erythema has disappeared.

There are still diarrhoea, headache, pain, prostration, and the same fever as yesterday.

April 20. A narrow red band of erythema has made its appearance around one side of the abdomen, and extending from the median line in front to the axillary line is a single chain of oblong vesicles, whose long diameters correspond with the circumference of the body and suggest by their distribution a zoster, although groups of vesicles are absent. In one place several of these vesicles have coalesced, producing a single long and narrow bulla. There are a few new bullæ about the ankles. The lesions upon the backs of the feet have dried into crusts. The erythematous element has almost disappeared from the thighs. The arms are both erythematous and itchy, and upon the anterior surface of the right wrist are two large wheals. The red patches which have appeared since yesterday upon the arms have that same peculiarity noted as existing upon the thighs—*i. e.*, that they seemed to be formed by an aggregation of minute vesicles whose fluid contents have in some way disappeared, leaving the summit of each minute lesion flat and shiny, resembling the condition seen in lichen tropicus of children. These patches are very itchy when they first appear, and the pruritus usually precedes the outbreak, as it also does each crop of bullæ. The paste employed has a very soothing effect on these patches.

Upon the areola of the left breast is an oblong bulla, whose contents have already become purulent, and upon the apex of the right nipple are two sago-pearl-like vesicles which make the nipple quite painful to the touch. A number of flat papules are seen upon the thighs to-day for the first time. The child is not put to the breast, but receives the milk after it has been artificially withdrawn.

April 21. Whole right side of face and a portion of the neck are of a bright scarlet color and have an infiltrated appearance. (Although it was anticipated that bullæ would be produced upon these patches, such was not the case, and the redness disappeared within a few days.) About twenty large-sized bullæ were carefully pricked and the contents allowed to escape, while the bleb wall was preserved to cover the surface beneath. The fluid

was of all colors, ranging from a clear, watery liquid to white, yellow, pink, and purplish (hemorrhagic). The temperature to-day reaches  $101^{\circ}$  in the axilla. Ten grains of calomel were given to relieve the bowels.

April 23. Patient sitting up. Feels quite well. Only a few new bullæ about the wrists, and the older lesions are healing. Temperature,  $98\frac{5}{8}^{\circ}$ .

May 1. Patient has continued taking Fowler's solution in eight-minim doses. Now has nausea, vomiting, abdominal pain, and the tongue has again become coated with thick, white fur. Arsenic was now stopped and a tonic mixture containing strychnine substituted.

May 3. There are some new vesicles on the arms and the skin is very itchy; also a few papulo-pustules and furuncular lesions upon the upper portion of the arms and in the axillæ. A number of bullæ have arisen upon the scar tissue of the arm mentioned under note of April 20.

May 7. Feels well again. Abdominal symptoms have disappeared. Several bullæ have formed on the arms and a group of small vesicles in the center of the right palm. Began Fowler's solution again in five-drop doses.

May 11. Few frank vesicles continue to appear upon the arms and backs of the hands. Boil-like lesions are still present in the axillæ and upon the chest. They are inflammatory, tender to the touch, and contain pus.

May 21. Patient has continued taking Fowler's solution for past two weeks, the dose being increased to eight drops three times daily. A few bullæ continue to crop out, but they are now flattened, do not become filled with fluid or get tense, and the diameter does not exceed that of a three- or five-cent silver piece. The secretion from these lesions quickly dries into yellow friable crusts like those seen in impetigo. The sites of previous lesions which have healed are now desquamating, as are also the palms. Vesicles in rounded groups are still present upon the soles, sides of feet, and insteps.

June 1. No new lesions have appeared since last note. Patient considers herself well and goes about. Treatment stopped.

June 20. Reddish pigmentations, which have marked the location of each lesion, are fading, and in doing so assume a brownish tinge. Patient has felt very well since.

July 11. Patient examined and found entirely free from any signs of dermatitis, with no indication of any recurrence. The arms are covered with various-sized rounded, brownish pigmentations, each the site of a former bulla, and patient says they appear to be growing gradually darker.

I have given to this condition the name *dermatitis multiformis gestationis*, because I believe that at the present time it is a more appropriate designation than any hitherto suggested. Had I employed any of the existing names by which to call it, I would have chosen that of *pemphigus gestationis* as the one most suggestive of its striking features. I am aware that in reading the description of the case one may say, "Oh, yes, that is an instance of my *herpes gestationis*," and another may recognize in it his *erythema gestationis*, while a third may put it down as *hydrops*, etc. Those who agree with Duhring that this condition is properly included in the group "dermatitis herpetiformis" will still possibly not object to the

name here suggested, since there is a decided feeling among dermatologists that "multiformis" is a more appropriate qualification than "herpetiformis," because the herpetic element is often absent in Duhring's disease when the case falls under observation. The objection made to this—that we have already an *erythema multiforme* with which it might be confounded—is not a valid one, for the distinction between an erythema and a dermatitis is marked, and there is no more similarity between the names than there is between those of *impetigo contagiosa* and *molluscum contagiosum*. If it should be decided that this condition, occurring in pregnancy or just after childbirth (which is now well recognized, though called by a great diversity of names), really forms a part of Duhring's dermatitis, then the termination *gestationis* will show to which particular variety of his disease these cases belong.

Naming the disease from the appearances presented at the time the case is observed will not answer in this polymorphous and ever-varying affection, which shows such a marked tendency to recur with successive pregnancies, but not always to present the same eruptive features. For example, how ludicrous it would appear if I should call this particular outbreak "pemphigus," and in her next pregnancy the patient should develop an eruption readily recognized as due to the same conditions and having many of the same features, but lacking the bullous element, and I should at that time report it as a case of "*herpes gestationis*, or *erythema gestationis*, a recurrence of *pemphigus gestationis* of the preceding pregnancy!" My friend, Dr. Brocq, of Paris, has recently advanced the comprehensive title *dermatite polymorphe prurigineuse récidivante de la grossesse*, forgetting for the moment that we do not all speak French, and even those who do, could scarcely speak so much of it at once whenever they wished to refer to this peculiar condition.

Concerning the nature of the affection, it appears to be of reflex nervous origin, and in the case here reported there is indeed the history of a shock to the nervous system by the premature rupture of the membranes and the consequent mental distress of the patient, who feared another miscarriage and was most desirous of bearing a living child. The analogy which exists between this dermatitis of gestation and the various herpetic affections is shown by the grouping in more or less regular circles and rounded groups, as upon the palms and foot-soles, and in the first lesions observed (a bulla at the navel surrounded in part by a chain of vesicles). A further analogy to that particular form of herpes known as zoster was to be noted in the chain of herpetic vesicles upon an erythematous base which encircled the right side of the abdomen.

An analogy between this case and those of *impetigo herpetiformis* of Hebra will be seen in the appearance of the first eruption toward the end of pregnancy, occurring about the umbilicus at first and having a central

lesion surrounded by smaller ones in the arc of a circle; in the fact that, although no lesions were positively pustular from the first, many soon became so, noticeably two which became confluent upon the areola of the left breast and those about the ankles. Furthermore, there were patches made up of miliary lesions, some with turbid contents. The resemblance to the descriptions of dermatitis herpetiformis, as given by Duhring and others, will be apparent; still, it seems to me that there should be a distinction made between the chronic conditions which go by this name and these acute attacks coming on in otherwise healthy individuals and depending upon the conditions furnished by the gravid uterus or the process of childbirth.

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## REPORT ON THE TREATMENT OF GONORRHOEA AND GONORRHOEAL CYSTITIS.\*

By E. R. PALMER, M. D.

SINCE my report on "Retractions in Gonorrhœa," presented to the Association in Washington in September last, fifty-five cases of recent disease of this character have been presented to me for treatment with, as a result, an average cure of all cases in 45.18 days. Of these cases, two were complicated by abscess of a cavernous corpus, which required external evacuation by the knife; and one, a laboring youth of eighteen, who was exceedingly irregular in coming for treatment, by epididymitis, while, as in my previous report, quite a number lessened the value of these observations by their irregular coming.

All of these cases have been private out-patients. The conditions favoring cure may therefore be said to have been only fairly good. All have been exceedingly anxious of cure, and have been watched and treated as long as shreds or gleety evidences appeared. In view of all this, the results are, to my mind, highly favorable to the mixed method of treatment.

This plan, which was outlined last fall, is at present practiced as follows:

Hot irrigation with a nozzle from the inception, except in very highly inflamed cases, beginning with solutions of the bichloride as weak as 1 to 30,000, and increasing gradually from day to day, more in obedience to personal idiosyncrasies than any other rule, with internally teaspoonful doses of citrate of potash repeated every few hours, the irrigation to be

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\* Read before the third annual meeting of the American Association of Genito-urinary Surgeons, May 22, 1889.

made with from thirty to sixty ounces of fluid, and to be used, if possible, twice daily.

As soon as the acuteness of the inflammatory process subsides, usually about forty-eight hours, or at once in those cases so commonly met that are from the beginning subacute, the mixed method should be applied after the following manner :

A two-gallon carboy, filled with a 1-to-500 solution of zinc sulphate and tapped by a long rubber siphon tube, is placed on a shelf seven feet from the floor. At the free end of the tube a rounded bit of quarter-inch glass tubing serves as a nozzle. At the completion of the hot irrigation this nozzle is brought against the meatus, the stop-cock on the siphon tube is opened, and the urethra ballooned with half an ounce or more of the zinc solution, which the operator skillfully retains there a moment or so with the thumb and forefinger of his left hand. In a large majority of cases two such treatments daily, with ordinary internal treatment, will suffice to accomplish absolute cure in three or four weeks' time. Occasionally it is well to give the patient ordinary self-injections, especially where he is inclined to be irregular in his coming.

Toward the end, in the majority of cases, it is well to change the bichloride irrigation from hot to cold, and quite frequently at such times it will be found better, and comparatively painless, to increase the strength of the solution to 1 to 15,000 or 1 to 7,500.

Experience has shown the bichloride of mercury to be incomparably superior to every other drug for purposes of urethral irrigation, and irrigation to be equally the superior of the Jacque-catheter method of retrojection.

When I assert that the typical fresh clap, as well as the subacute discharge relighted in a damaged urethra, may be permanently cured by these means in from a few days to six weeks, the true value of the method will be appreciated by those who find in the reports of André Martin and others, of more speedy cure in hospital practice, a reasonable ground to suspect half cures, with serosities bearing gonococci still present in the urethræ of at least a considerable percentage of the cases discharged as cured.

The distention to full extent of the urethra, and not infrequently the partial filling of the bladder with the zinc solution, daily, in all of the fifty-five cases forming the basis of this report, without subsequent prostatitis, or epididymitis, or cystitis, is to my mind not alone evidence of the safety, but also of the prophylactic power of this method of treatment.

A few obstinate and relapsing cases have extended the average time of cure, a considerable majority of the cases having been discharged well in about thirty days from the commencement of treatment.

## Society Transactions.

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### THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

R. W. TAYLOR, M. D., *President, in the Chair.*

(Concluded from page 271.)

#### SECOND DAY.

**Cases of Suprapubic Cystotomy.**—By DR. L. BOLTON BANGS, of New York. The experience of the writer in suprapubic cystotomy had been limited to six cases—two for the removal of tumors from the wall of the bladder, three for vesicular calculi, and one for the removal of a calculus, together with the excision of three small tumors (probably prostatic) from the internal urethral orifice.

In one case Dr. Bangs was obliged to find the bladder by means of a sound passed through the urethra, the rectal bag having been forced from the rectum during the operation.

The preparatory treatment advocated by Petersen and Perier in cases of contracted bladder or cystitis when present—namely, repeated injections—the author had not considered necessary, but operated at once in order to remove as soon as possible the cause of the bladder symptoms; neither had he found it necessary to resort to the transverse incision or to the elevation of the pelvis, both of which are advocated by Trendelenburg.

He made no attempt to secure primary union of the *whole* wound in the bladder, but in cases where the latter seemed to be in good condition he sutured it, excepting the small portion for the drainage-tube. In others the wounds were left open, together with the overlying tissues, in order to secure healing by granulation. After the operation the patients were not restricted to any particular posture, but he allowed them to choose their own posture. The abdominal decubitus formerly recommended by Trendelenburg was no longer considered necessary by him.

For drainage, Dr. Bangs found that one or two straight fenestrated rubber tubes, kept thoroughly cleaned by an antiseptic solution, answered the purpose admirably. After granulations had formed, a pad of absorbent cotton frequently changed would keep the patient's clothes and bed dry.

The author thought that the function of the urethra was more quickly restored and the openings in the bladder and abdomen more quickly healed when the patient assumed the upright position before the healing process was completed.

In each of two cases a fistula seemed inclined to persist in spite of the otherwise good condition of the patients. Thinking that this might be due to loss of tone of the urethra, a sound was passed, with the seeming result of enabling the patient to pass the urine in a larger stream and with greater force.



*Discussion.*

DR. WATSON said he preferred dividing the prevesical fat to pulling it up, especially when there was considerable of it. One might give a chance for the urine to flow into the place the fat had occupied and give rise to infiltration and decomposition. He thought Peterson's bag useful in assisting one to get into the bladder.

The double drainage-tube, he was convinced, had a distinct advantage over the single drainage-tube. A tube long enough to siphon was also very important indeed.

In the case of removal of papilloma the question as to the desirability of sewing up the bladder was an important one; if one expected any bleeding or consequence in the bladder, it was undesirable to sew it up.

He thought the suprapubic operation, whether for stone or intravesical growth of whatever sort, should not be done if they could be removed—in case of stone, by litholapaxy; in case of tumors, through the perinæum—because the percentage of deaths after suprapubic cystotomy was not so low as that of these other operations.

DR. BRYSON said he had seen a number of cases where the necessity of getting accurately and directly down between the muscles in the median line was disregarded, and where quite an infiltration into the prevesical space occurred. He preferred making the opening in the bladder as high up as possible. When the operation was properly done the drainage was remarkably good.

DR. KEYES, of New York, said he had gone through pretty much all the states of mind about the suprapubic operation. Approaching it with absolute dislike, he had come to consider it an admirable operation, but not the operation of choice except for sufficient reason. He had been quite shy about ballooning the rectum, and had never used more than ten ounces in the rectal colpeurynter. He did not see any object in distending the bladder larger than the fist or an orange perhaps. He thought the important points were to reach the bladder quickly by a clean cut, without tearing or pushing about with the finger in the prevesical space; that it was a good plan to roll up the fat that lay over the bladder in this position; that the suspensory threads were useful in steadying the bladder-wall, and that a small drainage-tube in front of the cut into the bladder-wall was of use in carrying away fluids that tend to gravitate into that position.

He had found it possible to arrest bleeding-points in the base of the bladder by carrying a suture under them with a curved needle, and had never found any harm to result from leaving catgut in such a position. In obstinate oozing he had been obliged to stuff the bladder with sponges for a time. In such a case much morphine was required to control the pain.

DR. CABOT said that there had been some effort to establish suprapubic cystotomy as the operation of choice for the removal of stones. Recent statistics by a Russian surgeon, Dr. Assendelft, were by far the best reported after this operation. Dr. Assendelft did suprapubic lithotomy in 103 cases with but two deaths, one of which he did not think was to be attributed to the operation. An analysis of his cases showed the patients all to have been

young, none of them having been over twenty-eight years of age, and the great majority of them having been under puberty. It was just at this age that any operation had its best success; and Assendelft's results should be compared with Freyer's (143 cases of lateral lithotomy in boys without a death). In litholapaxy done at all ages a percentage of about 96 recoveries had been obtained, and this was better than Dr. Assendelft's statistics, if we took the ages of the patients into account.

DR. CABOT preferred two drainage-tubes through the suprapubic wound, and he suggested helping the siphon action of these by attaching to them such a suction apparatus as the dentists used for carrying off the saliva during dental manipulations.

DR. BANGS said that in the two cases of tumor he decided on the suprapubic operation because they were tumors, and because there was a great deal of hæmorrhage before the operation. He preferred the suprapubic to the perineal operation because it offered immediate easy access to the bladder, and provided a wide field of operation. Only in one case had the cystoscope been useful in making even a probable diagnosis.

He resorted to the suprapubic operation in the cases of stone reported, because in each case the manipulation of instruments was hard and the detection of the stone difficult. In ordinary cases he would use litholapaxy for the removal of stones. For tumors, he believed that the suprapubic opening had decided advantages over any other.

He had seen no damage to the rectum which could be traced to its distention, although in one case he had found a tiny superficial anal fistula some time after the operation.

He thought the fat covering the bladder could more properly be called supravescical, and that it was better to pull it up out of the way than to cut down through it at the risk of starting venous hæmorrhage.

He asked the experience of other members in the use of Trendelenburg's position with the pelvis raised.

DR. KEYES, of New York, said that he had used it in one case with decided advantage.

**The Toxic Action of Chromic Acid used as a Cauterant.**—This paper, by DR. J. WILLIAM WHITE, of Philadelphia, was read by the secretary. The patient upon whom the application was made was a young woman, an inmate of the venereal wards of the Philadelphia Hospital. She had a mass of papillary growths covering the labia majora and nymphæ, extending toward the pubes and anus. The mass was several inches thick. After two weeks of preliminary treatment an application of half an ounce of a solution of chromic acid, containing one hundred grains to the ounce, was made. After this application the patient passed a restless night, and called frequently for water. Thirst continued all the morning without fever, and nausea supervened. At 3 A. M. she was pale, with cold extremities, pain in the left hypochondriac region, and fear of approaching death. The axillary temperature was 99° F. She died at 6.30 P. M., twenty-seven hours after the application of the acid. The intelligence was unimpaired.

The autopsy showed numerous fine ecchymoses in the stomach, the result of vomiting. The liver showed nutmeg change. The kidneys were the seat

of passive congestion ; their capsules were easily stripped off. Section of the vagina showed the mucous membrane dark-red in color, covered with yellowish discharge, with no evidence of contact with the acid.

A chemical examination of the viscera gave the following result : The kidneys and liver contained chromium—probably chromate of sodium—which was poisonous in doses of from one to three grains. The rectus muscle was free from chromium. The chromic acid in this case had probably combined with the sodium carbonate of the blood to form sodium chromate.

The text-books contained no word of warning against the danger of using chromic acid.

**A Case of Scirrhus of the Bladder (with Specimen).**\*—By DR. A. T. CABOT, of Boston. The author found signs of calculus when he first examined the patient. He was unsuccessful in crushing the stone with the lithotrite. He then performed suprapubic cystotomy, but on incising the skin and fat he struck a hard mass behind the symphysis, which he supposed to be a stone surrounded by the vesical walls. While cutting down upon it he opened the peritoneal cavity instead of the bladder. The mass was then seen to be a malignant tumor. The peritoneal wound healed by first intention, after being closed by the continuous suture. The supposed stone, as shown by the specimen, was really a calcareous deposit upon a portion of the tumor. The cavity of the bladder was greatly reduced in size. The perforation of the peritonæum during the operation was explained by the fact that it was drawn down upon the pubes in a remarkable manner.

#### *Discussion.*

DR. WATSON cited a case of prostatectomy which he did in September. The patient was seventy years of age, and he was under the impression that it was a tumor of the bladder, although he found no villi. The patient was bleeding to death. He found two very large lateral lobes of the prostate with a median bridge, and on the median bridge an area of granulation tissue, not cancerous, not new growth; apparently an ulcerated surface covered with proliferating granulations. This was the only source of hæmorrhage in the bladder. The patient recovered, and has never bled a drop since. In this case a gentleman of undoubted skill examined and thought he found tumor of the bladder.

DR. KEYES said, as far as his personal experience went, cancers of the bladder involving the wall of the bladder had one of two origins—prostatic, most often, extending from that backward into the bladder, or epithelioma distinctly on the floor of the bladder. Guyon had reported a case on the anterior wall of the bladder. No doubt epithelioma might occur independently at any part of the wall or body of the viscus. There was a distinct group—a source of great deception—the cylindroma or rectal epithelial cancer, that started high (two and a half to four inches) up in the rectum, and which sometimes involved and perforated the bladder wall. These cases of cancer, starting in the rectum and perforating the bladder, with symptoms of vesical irritability, should, in his opinion, be drained by suprapubic opening.

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\* See page 288.

DR. STEIN said the case of Dr. Cabot was one of interest in that a primary scirrhus was of the rarest formation in the bladder. Villous epithelioma occurred primarily in the bladder, and encephaloid occurred primarily in the bladder without involving the other parts. In the majority of cases of tumor, removal by the suprapubic method would, he believed, be found to be the best.

DR. BRYSON said he could not find on record a single case of cancer beginning in the seminal vesicles. He believed there had occurred in his practice two cases of that kind. Of course, the *onus* of proving that would rest largely on the clinical history. He thought some of these cases of malignant disease where we found the bladder involved and the rectum also had originated in the seminal vesicles. He did not see why it could not originate in the seminal vesicles as well as any other part of the body; and yet not only did we have no record of any such case, but it was distinctly stated, in most of the works, that they did not originate there.

He had recently operated upon a patient who presented papillomatous growths about the neck of the bladder with three pedunculate growths along the trigone to the right, the last one posteriorly being very near the exit of the right ureter. There had been much hæmorrhage. He could not use the cystoscope, because in passing it back it went through a mass of papillomatous growths and excited such bleeding that the whole field was obscured.

He had more than once been led to think, from examination with the finger alone, that a bladder wall was healthy when it was diseased. There were many of these soft growths which we could not appreciate with the finger introduced through the comparatively narrow neck, so that he believed that the suprapubic operation would give very much better advantages for inspecting and properly treating these cases than the perineal section.

DR. BANGS spoke of a case similar to those mentioned by Dr. Keyes, in which a cancer starting high up in the rectum perforated the bladder, and the presence of faecal matter, discovered by the microscope in the urine, was the first clew to the character of the disease.

He said that the suprapubic operation was the best in cases of tumor, for the proper diagnosis of the nature of a tumor was only made clear finally by the operation, and that procedure was therefore best which allowed of the most thorough examination. Further, in case of hæmorrhage, the suprapubic opening gave the best chance of checking it.

DR. WATSON thought that in case of benign tumors an extensive destruction of the base of the growth was not necessary, and that therefore the perineal route, which was safer, allowed sufficiently free access to the tumor.

DR. CABOT said that for the treatment of bladder tumors, when removal was contemplated, the suprapubic opening seemed the best. He thought that a valuable contribution to this subject of tumor of the bladder would be made if the members of the association would make public all the cases in which a new growth was seen by the cystoscope when no tumor existed. Dr. Watson had mentioned one such case, and he himself was cognizant of another, which he could only mention, as it did not occur in his own practice.

DR. BANGS said that he did not know how to account for some of the projections seen through the cystoscope. He thought they might sometimes be

due to partial contractions of the bladder under ether, and that great allowances had to be made for these possibilities of error in the use of the instrument.

DR. KEYES considered the cystoscope as somewhat dangerous in the way of exciting cystitis, as the heat could not always be properly controlled.

**Report of Three Cases of Chronic Cystitis of the Neck, resulting in the Formation of Hard Fibrous Rings at the Site of the Sphincter Vesicæ; with Remarks.\***—By DR. JOHN P. BRYSON, of St. Louis.

*Discussion.*

DR. KEYES said the variability of the contractile quality about the neck of the bladder was familiar to us all. Sometimes it was so soft as to be rotten. Occasionally it would not yield at all until you used forcible dilatation. He believed the lateral operation was the one to do under these circumstances.

DR. POST and DR. BANGS had observed these bands and were in doubt as to their mode of origin. Dr. Bangs thought them the result of hypertrophy from overfunction of the parts in an irritable bladder.

DR. STEIN thought them physiological and not to be interfered with.

DR. BRYSON said he had become less and less inclined to cut in the middle of the floor of the prostatic urethra in the fear of injuring the seminal ducts, and would prefer the lateral operation for these cases.

He thoroughly believed in the pathological character of these bands, and did not think that the simple hypertrophy of muscular tissue would account for so much resistance. He supposed the ætiological factors to be the same as were concerned in the formation of stricture.

**Rare Form of Urinary Concretion in the Bladder removed by Litholapaxy.**—By DR. GEORGE CHISMORE, of San Francisco. (Read by the secretary.)

The patient upon whom the operation was performed had suffered for several years from vesical distress, and had been treated by various genito-urinary surgeons for stricture of large caliber. When seen by Dr. Chismore he was passing large quantities of urine of low specific gravity, loaded with phosphates but devoid of albumin; it was at times alkaline, but not ammoniacal; micturition was frequent and occasionally painful, and he suffered from a constant discomfort in the prostatic region.

On examining his bladder with the stone-searcher Dr. Chismore touched a soft movable body; it was not gritty. After introducing the lithotrite, a body a centimetre and a half in diameter was found within the grasp. It imparted no feeling of *grit*, but seemed a fold of the bladder or a fleshy mass. After crushing it and washing it from the bladder, the fragments were found to consist of brownish matter, looking and feeling like small pieces of slippery elm; rubbed between the fingers, a few particles of sandy matter could be felt. When dry, the color changed to white, and the fragments assumed the appearance of tough, dry punk, interspersed with a few thin, small, iridescent scales.

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\* Will be published in a subsequent number of this Journal.

## NEW YORK DERMATOLOGICAL SOCIETY.

## 190TH REGULAR MEETING.

DR. E. L. KEYES, *President, in the Chair.*

**Lupus Erythematosus.**—DR. BULKLEY presented a case of this disease. K. K., female, seventeen years old, was never sick until the winter of 1885, when the ends of the fingers began to swell. At the same time red spots appeared and spread over the fingers and toes, and also on the face and scalp. Since that time the eruption has been present off and on, getting better in summer and worse in the winter, but has never been entirely well. In the summer the swelling would disappear, but the red spots remain. Last winter patient had headache nearly every day, but lately this has been better. The menstruation, which began in 1887, was regular up to January, 1889, but has not returned since. The parents are alive and healthy. There are three sisters also well and healthy. Another sister died of consumption in March, 1887.

The patient was first seen on April 24, 1889, at the dispensary, and the following condition was observed: On the dorsum of the right hand there were some whitish scars, others showing old pigmentation. About the center of the dorsum of the hand was a pea-sized macule, circular in shape, of a brownish-red color, not disappearing entirely under pressure, having a central depression, and showing a fine, adherent, yellowish fatty scale, which when removed showed prolongations into the deeper tissues. On the fingers there is a similar eruption, but of a more acute character. The lesions here are more on the flexor surfaces of the last phalanges. There is also a thickening of the fingers, and red circumscribed patches, and also some of a more dull red or even violet color, upon them. Here and there are small pustules surrounded by a red area and covered by a thin brownish crust, and also bluish nodules resembling very much pernioes. The nails are lusterless and brittle; the free margins are uneven and loosened from their base to a great extent. The left hand shows even more scars and patches similar to those already described. The toes are also similarly involved. On both cheeks there are a great number of small, white, scattered scars and red macules with central depression and a small scale, and there are also diffuse, sharply defined red patches. The sebaceous follicles are enlarged and a few comedones are present. There is a most distinct primary lesion at the inner canthus of the left eye. The ears are thickened and present scars, red patches, and pustular lesions. On the scalp there is in the middle line of the os frontis a bald patch one and a half inch in diameter, sharply defined, covered with thin, greasy, adherent scales. On the parietal bone there is a similar patch, and also small scaly lesions scattered here and there over the scalp. The patient also suffers from ciliary and conjunctival injection, pannus corneae, and excessive photophobia.

**Eczema Orbicularis seu Circumscriptum.**—DR. BULKLEY presented a case of this affection to show the effect of the internal administration of ergot in large doses. N. M., aged twenty-four, a Russian, presented himself at the New York Skin and Cancer Hospital (Dr. Bulkley's service) May 6, 1889.

The eruption from which he suffered had been present for nine months. It had begun on the calf of the right leg as a circumscribed spot the size of a five-cent piece, afterward on the right arm above the inner condyle, then on the corresponding place on left arm. The disease further appeared upon various portions of the body. The general health has been good; he has only suffered a little from constipation. On examination, there are found on the neck a few pigmented, circumscribed, slightly thickened scaly spots, and on back, shoulders, and chest some similar ones, which are round or oval and vary in size from a nickel to a fifty-cent piece. On the upper and lower extremities, especially on the extensor surfaces, are lesions of all sizes presenting characteristics as above mentioned. There is no weeping, but the lesions are covered with scales or small crusts; very itchy.

The patient was ordered, May 6th, to be given thirty drops of ext. fl. ergot three times daily, and to increase the dose every day by five drops until 3j was taken three times daily. The patient continued taking the medicine, and when presented, May 28th, was taking seventy-five drops three times daily. No bad symptoms had developed, but the lesions had disappeared, leaving dark-brown pigmentation.

**Case for Diagnosis.**—Presented by DR. CUTLER. The patient was an American, eighteen years of age, and having a good family history. He has had the present disease five years. The lesions constituting it began under the form of an elevated patch between the second and third fingers on the back of the left hand, which went on to suppuration. Since then a number of such tubercles have made their appearance on the back of the same hand. The disease has not made its appearance elsewhere. Some of the lesions have healed, leaving scars, but new ones made their appearance in or about the same area. One of the lesions was excised and healed and has not returned.

**Lichen Planus (Generalized) of the Palms, Soles, and Scrotum.**—DR. TAYLOR presented a case of this disease. Otto Smith, aged forty-three, barber, came to his clinic at the New York Hospital, May 28, 1889. He is a man of good habits, has had no sickness during life, and comes of a healthy family. For three years, beginning usually in the spring and lasting till fall and winter, he has had a rash similar to the present one. Examination shows on the arms, on the ulnar contour and extensor surfaces, on the lower abdomen, on the thighs, chiefly internally toward the knees, an eruption of lichen-planus lesions in the form of more or less perfect papules, papules which have nearly subsided, and pigmentation—all scattered and isolated; on the dorsum of hands, typical round and oval violet-colored papules; on the palms, chiefly in the center, groups of papules, ill-defined in shape; on the ball of the thumb, a linear distribution of papules, hard and horny. The same are found on the ankles and soles, and in the last site can be felt better than seen. On the scrotum are many patches, the seat of former papules, some showing an annular arrangement. The itching is very severe. The interest of the case centers chiefly in the rather unusual seat of the lichen lesions upon the palms and soles, and on the scrotum.

**Lichen Planus.**—DR. FOX presented for DR. ROBINSON a case of this affection on the backs of the hands and also on both elbows. The case was intended to show that isolated, pea-sized lesions can have scales in a mild, atro-

phic stage, and also for their unusual situation. The disease has been present two years.

**Verruca.**—DR. ELLIOT presented a case of this affection on account of the unusual situation of the lesions. The patient, a little girl twelve years of age, had a number of verrucae on the dorsum of the fingers, and, in addition, on the vermilion border of both the upper and lower lips and the alae nasi.

**Syphilitic Synovitis of the Knee-Joint.**—Presented by DR. SHERWELL. A male negro, aged fifty-six, a coachman. He states that he contracted syphilis twenty years ago. Ten years ago, after a cold, he had an attack of rheumatism, his knee swelling to its present size and remaining unchanged ever since. He had had, at the same time, an eruption resembling variola extending from the body down. He suffers from pain only in damp weather, and the knee is tender to pressure at the inner side of the patella.

**Case for Diagnosis.**—Presented by DR. ELLIOT. Patient, female, married, aged forty-six, was first seen April 19, 1889. She states that her disease began sixteen years ago with an itching in the hands and feet. This lasted two years and was accompanied by swelling. Thirteen years ago she had a catarrh of the nose and throat, and at that time the symptoms disappeared. The present eruption appeared in summer three years ago on the face and back, and was accompanied by a universal pruritus. The redness of the face is worse before menstruation, but is still always present. The eruption is located on both cheeks and occurs under the form of diffuse erythematous redness, small hard papules, and a few vesicles. There is intense itching and burning. The lesions are not grouped, do not undergo retrogressive metamorphosis, such as scaling, etc., but seem to persist, or, when they disappear, do so suddenly. On the back there are numerous small scars and scratch-marks, and also on the abdomen. In the interscapular region there is a large, diffuse, thickened, purplish-red patch, which is intensely itchy, dry, and slightly scaly. The patient suffers from indigestion and constipation.

DR. BRONSON thought the case was one of eczema. It was not uncommon or peculiar to see sudden disappearance from the face.

DR. SHERWELL also considered the case as one of eczema. The lesions on the face he would ascribe to intestinal derangement.

**Lupus Erythematosus.**—Presented by DR. SHERWELL. M. S., a woman, native of Ireland, aged twenty-nine, has been married five years, but suffers from her disease since 1877. The case is noteworthy on account of the unusual location and discrete character of the eruption. It is distributed over the whole of the surface above the clavicles to the crown of the head. It occurs in small patches with marked annular lesions around the eyes, almost occupying the favorite location of xanthoma. Another point of interest is the fact that the efflorescences, although never so numerous, have twice disappeared spontaneously. The disappearance or reappearance of the lesions did not occur at any particular time of the year, nor could anything in regard to the ætiology be observed. Most of the local remedies recommended by authors have been tried, and racleage of some of the lesions, but extension at the borders was always manifested afterward. The lesions around the eyelids have, owing to their situation, precluded any severe local treatment. The case was shown for the sake of advice in regard to treatment.



## Correspondence.

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### FIRST ANNUAL MEETING OF THE GERMAN DERMATOLOGICAL ASSOCIATION.

DEAR EDITOR: When, on the evening of Whitsunday, June 9th, the rooms of the German Casino, in the old city of Prague, were thrown open to welcome the members of the German Dermatological Society and to inaugurate its first congress, a large number of dermatologists from all parts of Germany and Austria began to pour in, a great many of them well known to you and to your readers. They were most cordially received by Professor Pick, the president of the society as well as of the congress, who, with the aid of his amiable family, succeeded in rendering the social aspect of the congress as pleasant and satisfactory as possible, while the business part, with equal success, was principally directed by Professor Neisser, of Breslau. Among those present, the Austro-Hungarian Empire had sent the largest number of representatives, among them Kaposi, Neumann, v. Zeissl, Grünfeld, Finger, Ehrmann, Janowsky, Rona, Havarz, Lipp, and others. Breslau was particularly well represented by Professor Neisser and a number of his former and present assistants, some of them occupying prominent positions in different cities in Germany, like Arning, of Hamburg; Lesser, of Leipzig; Epstein, of Nürnberg; Touton, of Wiesbaden, etc. Berlin was represented by Behrend, Rosenthal, Lassar, Joseph, Blaschko, and others; Königsberg, by Caspary and Morhelson; Bonn, by Bender and Doutrelepoint. Veiel, of Canstatt, Oberländer, of Dresden; Petersen, of St. Petersburg must also be mentioned. Lewin, of Berlin, and Kopp, of München, who had announced papers, were prevented from coming. Among other dermatologists, Lang, of Vienna, Köhner, of Berlin, and Unna, of Hamburg, and his school, were prominently absent.

The meetings of the congress took place from 9 to 12 A. M. and 3 to 5 P. M.—all, except one, in the lecture-room of the Anatomical Institute, on account of the unusual warm weather which prevailed through May and June all over the European continent, only one being held in the dermatological clinic of Professor Pick. In spite of the trying conditions of the weather, all the meetings were very numerously attended. The number of papers announced and accepted was entirely too large, so that some of them could not be read at all, others had to be shortened, while against others the rules of the congress allowing fifteen minutes for each paper were relaxed unduly and unjustly. The time for discussion was therefore very limited and the debates were very incomplete and unsatisfactory, even on those questions which were intended to be brought prominently before the congress, like lepra, gonorrhœa and its relations to the gonococcus Neisser and to endoscopic treatment, and the treatment of syphilis by insoluble mercurial injections. Quite a number of the papers were really introductions to the demonstration of microscopical preparations on bacteriological and histological subjects which were exhibited in several halls of the upper story of the Anatomical Institute.

The first subject placed before the congress was lepra. Arning, of Hamburg, reported on his case of inoculation of lepra, which is well known to you. Numerous plaster-of-Paris casts of leprous individuals were of great interest. Petersen, of St. Petersburg, demonstrated a number of photographs of leprous individuals, maintaining that in the Baltic provinces of Russia lepra is spreading rather than representing the remnants of an evanescent endemic occurrence. Both authors seemed to put but very little faith in the effect of therapeutic measures, attributing rather the involution of some of the products of lepra to a spontaneous tendency of the disease, wherein they were confirmed by Kaposi, who on the second day exhibited a case of lepra developing on a syphilitic individual. To salicylic acid was conceded about as much effectiveness as to other remedies. The remarks of Professor Neisser on histological details were mostly directed against Unna's publication, which Neisser contradicted on every point.

The second question brought into prominence by an elaborate report of Professor Neisser was gonorrhœa and the position to be conceded to the gonococcus Neisser, the importance of which had been denied by some others, particularly by Oberländer. While in general the diagnostic value of the gonococcus was not doubted, the importance of the endoscopic examination of the condition of the diseased urethra and its treatment by local means were maintained by others.

The principal question of the third day was the treatment of syphilis with injections of insoluble mercurial salts, the dangers of which had been pointed out by Lesser, of Leipzig. Altogether, the general impression seemed to be that the advantages of this method are too great to be given up on account of occasional mishaps, but that more caution is necessary in its application than was used in the fatal case reported by Kaposi. A paper of Dr. Winternitz, of Prague, on the quantitative analysis of mercury and its practical application to the different methods of antisymphilitic mercurial treatment was very exhaustive and interesting. Some of the papers on syphilis which promised to be of more practical interest were not read at all, but will probably be published with the transactions of the congress.

Professor Chiari's paper on further contributions to the knowledge of orchitis variolosa was quite elaborate and interesting, although very little related to dermatology, while Zeissl reported on the lymphatic vessels of the male genital organs.

Dermatology proper, particularly its clinical and therapeutical aspects, occupied but little of the time of the congress, a feature not very satisfactory to many of the dermatologists present. Kaposi, in a report on a recent epidemic of zoster, tried to prove the infectious nature of the disease. The most interesting meeting was the fifth one, which was held in the clinic of Professor Pick, who presented a number of cases which had been the subject of former publications—viz., of urticaria pigmentosa, of melanosis lenticularis progressiva (xeroderma pigmentosum), several members of one family, and demonstrated his method of treatment of eczema by means of salicylic-plaster bandages.

Whether the first congress of the German Dermatological Society has advanced dermatology in a prominent degree, and whether it has done any-

thing to decide or bring much nearer to a solution some of the questions which were brought more prominently before it, this question will be answered more fully after the appearance of its transactions, which will be published shortly as a separate number of the "Archiv für Dermatologie."

It remains to add a few words on the social features of the congress. On Monday evening, the 10th of June, a performance of opera was given in the new German Theatre in honor of the members of the congress, after which they were united at a reception in the hospitable house of Professor Pick in unrestrained, pleasant conversation until late hours. On Tuesday, the 11th, after the laborious sessions, the congress assembled for the "Festessen" at the German Casino, which passed off very pleasantly under numerous speeches. Although the festivities of the third day—concerts in several of the public gardens—were marred somewhat by thunder-storms and rain, undoubtedly all the members of the first congress left Prague with a pleasant remembrance of the meeting.

KLOTZ.

EISENACH, July 5, 1889.

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## Selections.

### Trichomycosis Nodosa.

UNDER this designation Dr. Patterson describes, in the "British Medical Journal," May 25, 1889, a peculiar condition of the hairs of the axillæ and scrotum, due to the growth and encapsulation in the cortical layers of the shaft of a small rod-shaped bacterium. This nodose deformity of the hair Paxton called attention to some twenty years ago, but since then it has been confounded with trichorrexia nodosa, and has been regarded by some observers as due to maceration of the hairs in these situations and to a deposit upon their sheaths. Wilson described the disease under the name *lepothrix*.

The hairs appear abnormally dry and dull and feel rough and knotted. The knotting may be nodular or diffuse. The hairs are not abnormally brittle excepting at the nodules, where they tend to break off. This is usually in the middle third.

The bacilli which compose the mass travel up the shaft until they find a part suitable for their development. They are never found in the follicle. They lie together in the cortex of the shaft, but do not penetrate deeply into the hair. The maceration loosens the epidermal scales and allows an entrance into the parts beneath. They burrow into the hair, and the pressure of their growth causes a longitudinal splitting of the cortical fibers. A homogeneous or slightly granular substance, which lies between and around the bacteria, as it were encapsulating them, forms the surface projections or nodes. This substance is exactly similar in appearance to that with which pediculi fasten their ova to the hairs. The bacilli are described as short, fine rods, with slightly rounded ends, two to three times as long as broad, and about one fourth the diameter of a red blood-corpuscle. They are best stained by

Gram's method. Sometimes two or three are joined together, but seldom form longer threads. Ordinary methods of culture fail.

In a note, Behrends's description of a similar nodosity of hair, in "Virchow's Archives," which had been overlooked by the author, is referred to.

### Treatment of Psoriasis with Hydroxylaminum.

In an article upon the value of this new remedy in the treatment of psoriasis Dr. Fabry gives his experience after observing twenty-four cases thus treated in the service of Dr. Doutrelepont, of Bonn ("Archiv für Dermatologie und Syphilis," Heft 2, 1889).

Hydroxylamin was first obtained by Lossen, in 1865, from the reduction of nitrous acid; it is one of the bodies allied to ammonia,  $\text{NH}_3$  being ammonia and  $\text{NH}_2\text{OH}$  hydroxylamin, and, like ammonia, has the peculiarity of readily entering into combination with hydrochloric acid.

$\text{NH}_3\text{HCl}$  = sal ammoniac.

$\text{NH}_2\text{OH.HCl}$  = hydroxylamin muriaticum.

The hydrochloric combination of hydroxylamin is characterized by its ready solubility in water, alcohol, and glycerin, and these combinations turn blue litmus-paper an intense red.

It is a narcotic and produces paralysis of the nerve centers, and in large doses produces convulsions and death. Experiments upon animals and upon blood outside of the body have shown that oxyhæmoglobin of the blood is transformed by hydroxylamin into methæmoglobin by abstraction of oxygen. This reduction property which it possesses is very energetic and rapid.

In treating psoriasis, the author employs either an alcoholic solution, such as:

℞ Hydroxylamin muriat. .... 0·2-0·5  
 Spirit. vini. .... 100·0  
 Calcar. carbon. .... q. s. ad neutr.

D. S.: Apply with brush.

Or a watery solution, applied as in a hydropathic band:

℞ Hydroxylamin muriat. .... 1·0  
 Aquæ font. .... 1000·0  
 Calcar. carbon. .... q. s. ad neutr.

D. S.: Apply as wet cloth.

As in other applications, the scales are to be first removed by bathing, rubbing with green soap, and applications of ten-per-cent. zinc salve. As this new substance has decided toxic properties, the 1-to-1,000 or 1-to-500 neutralized solution is used in the beginning, and the stronger applications, up to one half per cent., are gradually employed, being painted on the diseased areas twice daily. A cloth wet in the solution, or a Priessnitz band, can be applied every two hours to suitable parts. As is the case with pyrogallol, chrysarobin, and some other substances, albumin may appear in the urine as a consequence of absorption of the drug. So far as a radical cure of psoriasis is concerned, hydroxylamin promises no more than the substances now used as external applications, recurrences appearing to be quite as frequent as after older methods. The features of this new remedy which recommend it are its cheapness, the fact that it does not stain the

clothing, and does not produce dermatitis of the healthy skin in the way chrysarobin and pyrogallol do, while being quite as active an agent in removing the lesions of psoriasis. So that the author does not hesitate to advise its use in this disease.

So far as the length of treatment required to remove the lesions is concerned, it appears that the action is not more rapid than that of chrysarobin, a four- to six-weeks' course being necessary. In the degree of effect produced it does not fall behind that of other reduction agents now in use, but its effects upon the system must be watched. In some patients, so much pain from the stronger applications is complained of that other means have to be substituted or the treatment intermitted.

Eichhoff is reported to have had some good results with the remedy in lupus, herpes tonsurans, and parasitic sycosis.

### Electric Illumination in Obscure Vesical Disease.

DR. FENWICK writes in the "British Medical Journal" of May 4, 1889, after fifteen months' experience with the electric cystoscope, that unremitting practice is necessary to avoid visual errors both in the healthy bladder and that the seat of disease.

The first normal pitfall to which he draws attention is a slightly prolapsed ureter which so resembles a sessile tumor that he has known a surgeon desire to operate upon it.

Rugæ are formed by contracting muscle, which, when seen in profile, appear like rows of papillomata. In hæmorrhagic cystitis such rugæ very markedly resemble multiple villous growths. Rectangular quiltings are observed in chronic cystitis, the inclosed patches projecting forward sometimes as though pushed up by the tips of many fingers.

Phosphatic and incrustated growths are sometimes exactly like stones; but a touch with the tip of the instrument will settle the matter.

Hæmorrhages form elongated, oval, or roundish elevations, sometimes very similar to epithelioma. Most mistakes will probably be made in tuberculosis. "Cockscorn-like projections of swollen mucous membrane mimic the stunted papillary fibroma." He agrees with Nitze that digital exploration is quite needless in the greater number of obscure cases, the electric light being equal to the finger. He has used the light in forty-three obscure cases, and finds the advantages it possesses over Sir Henry Thompson's method to be that it is much simpler, can be done without an anæsthetic or confinement to bed, and is free from risk. The eye is more to be relied upon than the finger, etc.

Fifteen cases of vesical tumors are detailed, and out of a total of twenty growths in the bladder the author has found but two of a benign nature, which is contrary to Thompson's statement that villous growth (papilloma) is the most frequent. In fact, the author claims to have found in the museums of Europe from one hundred and fifty to two hundred instances of carcinomatous vesical growth without difficulty, while but fifty specimens of undoubted papillomatous growths could be discovered.

He takes exception to the dictum of Professor Gross, that if hæmaturia precedes the irritability and pain, with long intervals of rest, the tumor is probably benign, and that if irritability and pain appear first, it is usually

malignant. Most of his fifteen cases have had painless hæmaturia as an onset symptom.

A firm, benign growth, situated near the orifice or so pedunculated as to readily engage the sensitive neck, will excite pain and irritability at an earlier period, or any growth, by exciting cystitis, will evoke similar symptoms. Vesical carcinomata originate usually on the posterior wall, just behind the ureteral orifices, and grow toward the best blood-supply.

### Hysteria and Mercurial Poisoning.

IN his lectures at the Necker Hospital, Dr. Rendu presented a patient, thirty-eight years of age, admitted ten days before with incoördination of motion, marked trembling of all the limbs, but especially of the lower extremities, so that the least movement brought on decided oscillations. At the present time the movements cease when the patient lies in bed, but the least attempt at motion, even in the recumbent position, brings on quite intense trepidation. Flexion produces more spasm than extension. The trembling is characterized by large oscillations, and not by small ones, as in alcoholic intoxication. The muscle itself has an exaggerated tonicity, and the slightest percussion determines an extended reflex upon the neighboring muscles, showing the existence of a peculiar condition of the spinal cord, and since, lying in bed, he can execute all movements which he is told to, with sufficient force and without the least exaggeration, the condition is not one of true ataxia, though in walking the limbs are thrown about just as in the latter disease, and if the eyes are closed while upon his feet, he falls at once. Troubles of sensation are also present, such as fulgurating pains in the lumbar region radiating toward the upper parts of the thighs, in the region of the knee joints radiating toward the malleoli, etc. Even if this were a case of ataxia it would not be one of tabes, since the tendon reflex, far from being suppressed, as in ataxia, is exaggerated, and, besides the trembling, has not the character of that of ataxia. In pseudo-tabes there is a tendency to peripheral lesions of nerves more than to a spinal state. It is met with especially in alcoholics, in infectious diseases, lead and oxide-of-carbon poisoning, in hysterics, and is always accompanied by a certain degree of paresis and diminution of force. In alcoholic pseudo-tabes the patients complain generally of persistent pains in certain groups of muscles, notably in those of the calf, and there is almost always a diminution of the tendon reflex. Spasmodic tabes is a rare affection, analogous to this case, but showing also muscular paresis and contraction here absent. The peculiarities of this case are that the trembling began in the lower extremities, that the head has not been affected, and that this man has had no loss of power, contrary to what usually happens in mercurial poisoning. In looking into the antecedent history, we find that the patient is a well-recognized hysteric, who has been treated by Charcot at the Salpêtrière, having had hemiplegia with complete sensory and sensitive anæsthesia at one time, and paraplegia of both lower extremities and general anæsthesia at another. At the same time, however, he is suffering from the effects of mercury upon the system, and it is well known how this metal has an influence to bring forth hysteria in men. Up to the age of twenty-seven this man was well; he then began to work in the manufacture of hats, being

exclusively employed in preparing rabbit skins, in which, as is well known, nitrate of mercury is used.

Within a year the system became impregnated with the mercury, and trembling of the legs began. After three months' hospital treatment he went back to work, but within two months became salivated, and since that time the trembling of the legs has never ceased.

Treatment has consisted in an evening dose of two grammes of bromide of potassium and a morning dose of thirty drops of tincture of valerian. Besides this, he has had hydrotherapy, and, if improvement is not satisfactory, prolonged baths and the continuous current of electricity will be used.—*Gazette des hôpitaux*, March 12, 1889.

### **Xeroderma Pigmentosum.**

IN the "British Medical Journal" of June 8, 1889, Dr. McCall Anderson publishes the report of a typical case of this rare disease, accompanied by a chromo-lithograph, which gives an excellent idea of the condition.

The patient was a boy, nine years of age, whose parents were healthy, but whose sister was similarly affected, and died, at the age of nine, of some affection of the chest. "Freckles" began appearing upon the face and neck of this patient at the age of two years, entirely disappearing during the winter, but returning each summer with increasing intensity. For several years they have been permanent and become very dark, some almost black. The neck, forearms, hands, legs, and feet are now all implicated. Within the past ten months telangiectases, cicatrices, and small warty-looking nodules have appeared upon the face. Upon the ears the capillary vessels are much dilated and conspicuous. Small, white, glazed atrophic areas, surrounded by a zone of dilated capillaries, are here and there to be seen.

So great a tendency has this disease to set in in the spring and summer that Vidal and Neisser are of opinion that insolation may be an exciting cause. Though almost invariably beginning in early youth, two cases in Crocker's table were nine and sixteen, respectively, when the disease first showed itself. Sooner or later after the pigmented spots, identical with "freckles," have appeared, the second stage comes on, consisting of telangiectases between them, but not so numerous as the dark spots. In the third stage many of the dilated capillaries are replaced by an atrophic condition. In the last stage, which may not appear for many years, the spots become warty and ulcerate; and fungoid growths develop, which sooner or later terminate the life of the patient. In the case reported these growths are epitheliomatous in character. There is little or nothing known of the true nature of this curious affection, and treatment must be conducted on general principles.

### **Treatment of Purpura Hæmorrhagica by Nitrate of Silver.**

DR. POULET ("Bull. gén. de thérapeutique," May 3, 1889), who is a firm believer in the division of purpuras into sthenic and asthenic forms, says the former is easily recognized by the pulse and the general condition of the patient. The vessels do not rupture because their structure has become altered, but because of the repletion of the whole circulatory system. This form is relatively benign, and bleeding renders service by diminishing the

plethora. The asthenic form includes the cachectic purpura whose termination is so often fatal. The author believes that the presence of bacilli in the capillaries, causing accumulations and coagulation, has been wrongly accused of causing the condition. He has found the internal administration of nitrate of silver superior to all other remedies hitherto employed, such as perchloride of iron, ergot, rhatany, etc., acting almost as a specific. Two cases are recorded out of a number thus treated. The first was a very severe case of Werlhof's disease in a child of twelve years. The losses of blood were copious and frequent. There were prostration, yellow discoloration of the skin, and loss of flesh. Other methods had failed, and tamponing the anterior nares had not checked the flow of blood. One sixth of a grain of silver was given in bread-crumbs pill, twice daily, half an hour after eating. Improvement began at once. The purple spots began to disappear, the pulse became stronger, and the patient rapidly recovered, but remained delicate for many years. In the second case epistaxis, stomatorrhagia, and enterorrhagia had resisted all other methods of treatment. Improvement had taken place under the action of strophanthus, but the hæmorrhage and purpuric eruption only gave way to nitrate-of-silver pills in doses of eight milligrammes ( $\frac{1}{8}$  grain) three times daily. Only twelve pills were required to effect a cure. Relating to the manner in which the agent acts to secure such good results the author says that, from what we know of the dynamic action of this substance upon the nervous system in diseases of the spinal marrow, in epilepsy, and in the various neuroses in which the perversion of function of the great sympathetic plays a most important rôle, we are led to believe that the nitrate of silver modifies the capillary circulation in a profound degree by making an impression on the vaso-motor nerves. Where there is a malarial origin to account for the purpura, the nitrate of silver must cede the place to heroic doses of quinine—the remedy *par excellence*.

### Syphilis and Eczema Seborrhoicum.

UNNA thinks a large number of well-known syphilides to be a sort of mixed infection of eczema seborrhoicum and syphilis. The intermingling of a seborrhoic eczema with syphilis is to be suspected where the single efflorescences of the exanthem are various in size, sharply edged, and confluent, where papules are partly lacking the specific syphilitic color and appear freshly yellowish-red, where smooth papules are completely lacking, and, on the contrary, covered with scales and crusts.

Further, where the papules are arranged in serpiginously progressive circles and rings, where around the papules, and especially in the centers of the serpiginous eruptions, the peculiar yellow of a seborrhoic process is present. Again, where the exanthem is accompanied by the symptoms of eczema, as humid discharges, heat, and tension.

Further, in every place where there is slight or more violent itching, the syphilides in the edge of the hair on the forehead, in the naso-labial furrow upon the sternum, between the shoulder blades or in the sacral region, when they chiefly or solely appear upon the hairy parts of the head, in the axillæ, on the mons veneris, genitals, and arms—in short, upon hairy places and points of contact, and, finally, when the exanthem shows an extraordinary



resistance to treatment, where, upon the contrary, an anti-seborrhoic local treatment (resorcin, sulphur) causes an immediate improvement or recovery. —*Monatshefte für prakt. Dermatolog.*, 21, 1888.

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## Book Review.

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*Lehrbuch der venerischen Erkrankungen* (*A Text-book of Venereal Diseases*). By Dr. C. KOPP, Docent in the University of Munich. Berlin : Frederick Wreden, 1889.

THIS book, which forms Volume XIV of Wreden's collection of short medical text-books, maintains the reputation of this series, which already contains such excellent works as Schmidt-Rimpler on ophthalmology, Fritsch on diseases of women, Baginsky on diseases of children, etc.

Dr. Kopp is favorably known to the medical public as the author of numerous journal contributions to the literature of our specialty as well as by his work, "Tropho-neuroses of the Skin," published in 1886 by Braumüller, of Vienna. His position in the venereal clinic at Munich has afforded him opportunity to speak with a degree of authority concerning the subjects contained in the book before us.

It has been his aim to write a text-book embodying the newest ideas concerning the pathology and treatment of the venereal diseases, while neglecting in no way the more practical part of his subject. He accepts with the majority of modern writers the ætiological rôle of the gonococcus, and gives full details for its detection in suspected discharges.

The description of the pathological changes which Bumm's investigations showed were characteristic of the disease as it affects the conjunctiva are transferred to the urethral mucosa in explaining the alterations produced by the microbe.

The usual rules as laid down in German text-books for the differentiation of posterior from anterior urethritis are given. While admitting the occasional usefulness of the endoscope in skilled hands in the detection and treatment of chronic affections of the urethral canal, he is not as enthusiastic in regard to the necessity of this method as some of his German *confrères*.

His chapter on the treatment of the disease, both in its acute and chronic forms, is in the main satisfactory, embodying the methods of Unna, Finger, and Oberländer. He does not, however, mention the American plan of treating acute urethritis by overdistention of the canal with repeated irrigations of a bichloride solution. In chronic urethritis he claims to have had the best results from dilatation, followed by the injection of a weak solution of nitrate of silver.

Whether the so-called chancroid is always the result of one and the same micro-organism or can be produced by pyrogenic organisms of various kinds, as held by some modern writers, he considers not yet decided.

Italian investigators (Lorenzo Mannino, De Lucca, and Primo Ferrari)

have attempted to isolate and cultivate the virus of the chancroid, but have not yet arrived at corresponding or satisfactory results.

The main body of the work, comprising some four hundred pages, is devoted to the consideration of syphilis, which he regards as of bacterial origin, the nature of which, however, is still one of the dark chapters of pathology.

The modifications in the character of the initial sclerosis, caused, as shown by Finger's investigations, according to the number and distribution of the blood-vessels at the place of infection, are described.

The author's views on the pathology and diagnosis of the various syphilitic manifestations are to be commended as complete and fully abreast with the times. The chapters on malignant syphilis, hereditary syphilis, and on the treatment of the disease are to be mentioned as especially worthy of attention.

The fatal result in some cases of hereditary syphilis, owing, as shown by Kolisko and other Vienna investigators, to secondary pyæmic infection, starting in the umbilical cord, is not alluded to.

The author is in accord with Neisser and the German school of syphilography concerning the nature of leucoderma syphiliticum, formerly, and still by French and some American writers, considered as primarily an increased pigmentary deposit in the skin. If observed in the beginning it will be seen to be primarily a leucoderma, affecting generally the throat and neck, and occurring in those spots from which a macular or papular syphilide has shortly disappeared.

An increased deposit of pigment surrounding the spots of leucoderma takes place at the same time, and may in time obscure the original appearance.

A colored drawing of endarteritis syphilitica is reproduced from Finger's book on syphilis, as well as one representing the syphilis bacilli in the tissues from Lustgarten's monograph, both of which add to the value of the work.

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## Items.

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**Omission.**—By an inadvertence on the part of the reporter, the name of Dr. R. W. Taylor, the president of the third annual meeting of the American Association of Genito-urinary Surgeons, was omitted in the heading of our report in the July number of this Journal.

**International Atlas of Skin Diseases.**—We learn that an international atlas of rare skin diseases will be published under the joint editorship of Dr. P. G. Unna, of Hamburg; Professor Leloir, of Lille; Dr. Duhring, of Philadelphia; and Mr. Malcolm Morris, of London.

Each plate will be accompanied by a descriptive text, which will be printed in English, German, and French.

Contributions to this atlas must be sent to the editor of the country in which they are written, and are accepted on the ground of rarity and importance and on the condition that they have not been hitherto published, or only in works not easily access-

ible to the majority of dermatologists. The description of the disease must be as concise as possible, and must include:

1. History, course, and treatment.
2. Pathology and aetiology, history, bacteriology, pathological experiments.
3. Differential diagnosis (at greater length).
4. Opinion of author, briefly, upon the nature, place in the system of classification, and name of the disease.

Mr. Lewis, of Gower Street, will be the English publisher of the work, from whom further particulars as to price, etc., may be obtained.

**Prognosis in Cephalic Chancre.**—Dr. Stourme ("Lyon médical," June, 1889) has collected over one hundred unpublished instances of chancre upon the various regions of the head, to solve, if possible, the question whether the initial lesion in this situation is more rapid in its development and of a graver prognosis than chancre located upon the genitals. In other words, does syphilis show an analogy in this respect to rabies, which shows a more certain and more rapid development when the face is the part bitten? The following conclusions are arrived at:

The primary incubation of chancre upon the head is from fifteen to thirty-five days. Its duration presents nothing unusual, lasting on an average forty-nine days. The second period of incubation, instead of being six weeks, as in genital chancre, has been found by the author to be only thirty-eight days. Secondary manifestations are not more severe than those usually seen. Sufficient time has not been given to make observations upon tertiary lesions. Specific treatment has as favorable effect upon the later manifestations as in genital syphilis.

**Tinea Tonsurans treated without Epilation.**—In one of the recent clinical conferences held at the St. Louis Hospital by Dr. Vidal, the treatment of tinea tonsurans was discussed. He first has the head washed with essence of turpentine, after which the whole scalp is covered with tincture of iodine, a portion only of the scalp being rubbed at one time. Twice a day after this the whole head is to be covered with vaseline and a rubber cap worn. The trichophyton is thus deprived of oxygen, and being, as is supposed, an air-breathing parasite, is placed in an unfavorable condition for development.

**Chancre of the Lip.**—A patient in Vidal's service who had an initial lesion of the lip gave an interesting history of its origin. She was a young lady, aged twenty-one, who for three months had had an eczema of both lips, especially the lower. On admission to the hospital, the lower lip was found thickened, indurated, and presented the appearances of a chancre, with enlarged submaxillary glands of both sides. A roseola soon followed. The patient had worked in a shop at the same time with a young man who had "sore lips." Both used the same speaking-tube, applying the lips closely to the mouth-piece, and she thinks that in this way the sore was acquired.—*Journal de médecine*, June, 1889.

**Hereditary Syphilis.**—Professor Neumann, in a recent session of the k. k. Gesellschaft der Aerzte Wien's, basing his observations upon a hundred and nine cases, came to the following conclusions:

1. The syphilitic mother may in every stage of her disease, from infection before as well as after conception, transmit the disease to her offspring.
2. The mother affected after conception sometimes transmits syphilis to the foetus.
3. If infected after conception, and if the father was syphilitic at the time of procreation, then the influence is much more intense. The children die *in utero* or are born syphilitic.
4. In post-conceptional syphilis, if the infection be unknown, then the relation is

the same as in preconceptional. Syphilis acquired in the last months of pregnancy is rarely transmitted to the offspring.

5. If infection and conception be simultaneous, then half of the children die. Children may be born, however, when both parents at the time of conception are syphilitic.

6. Infection before conception depends upon the time when occurring. The further removed from the time of conception, the more favorable the prognosis for the offspring.

7. Those mothers who have acquired syphilis only in the last month of pregnancy, while the father at the time of conception was healthy, offer the best prognosis for the children. The same holds good for tertiary syphilitic patients. The worst prognosis is in those cases where the time of conception and infection go hand in hand or where the father at the time of conception suffers from recent syphilis.

8. Especially do those cases show the dangerousness of the paternal syphilis in which the father was syphilitic at the time of conception, the mother only becoming infected after conception and the child soon after infection being born macerated. This contradicts Boeck and Onver, who assert that the child of a syphilitic father is healthy.—*Deutsche med. Wochenschrift*, March 7, 1889.

**Psorospermial Cysts of Ureters.**—Mr. Eve showed a specimen at the London Pathological Society, May 21, 1889, in which the upper parts of both ureters were studded with small miliary cysts having milky contents. Microscopical sections showed cysts filled with colloid material and ovoid bodies corresponding in appearance and size to *psoro-naricella*. The subject was a woman of fifty-one, who had a sudden attack of hæmaturia. Death took place seventeen days later from anæmia and exhaustion. Such cysts have previously been found in the human subject beneath the capsule of the kidney and in the liver; but they are very rare, though not uncommonly found in some domestic animals, especially in the liver of rabbits.

**Recipes for Preparations of Iodol.**—(“Pharm. Post.” 1889, No. 5.)

Iodol solution:

R Iodol.....	1·0
Alcohol.....	16·0
Glycerin.....	34·0

Iodol gauze:

R Iodol,	}	.....	āā	1·0
Resinæ,				
Glycerin,				
Alcohol.....				10·0

Collodion with iodol:

R Iodol.....	10·0
Alcohol (94 per cent.).....	16·0
Ether.....	64·0
Pyroxilini.....	4·0
Olei ricini.....	6·0

—*Monatsshefte f. Prak. Dermat.*, B. viii, No. 9.

**Paget's Disease of the Nipple.**—M. Darier, from recent observations, has been led to conclude that Paget's disease of the nipple is a new form of cutaneous psorospermiosis. Paget's disease is distinguished from ordinary eczema by the fact that it is limited by a well-marked edge, and that the skin becomes parchment-like. The affection is incurable and is invariably followed by cancer. M. Darier examined epidermic scales taken from the affected parts, and mixed them with water or potassium iodide, or macerated them in diluted ammonium or bichromate of ammonium. He detected among the

epithelial cells and in their interior round bodies surrounded by a double-edged membrane. The diameter of these bodies was equal to or greater than that of the cells: their membrane contained a single mass of protoplasm or globules. They were invariably present in all the sections of the pieces of skin excised, in every layer of the epidermis, and especially in the glandulae of the skin. These bodies were undeniably psorospermiae or conidia. Epithelioma of the nipple contained similar parasites in the buds and a number of elements usually inclosed in other cells. It is well known that the presence of these organisms in an epithelial tissue determines the budding of this tissue. Cases of epithelioma containing conidia in their buds have more than once been recorded. M. Darier considers it clear that Paget's disease of the nipple is caused by these parasites, which determine the budding of the galactophorous ducts.—*British Medical Journal*, June 1, 1889.

**Syphilitic Diabetes.**—Lemmonier gives an interesting casuistic contribution to syphilitic diabetes. A patient, treated a long time in vain with a well-known anti-diabetic regime and infected twenty years ago, presented one day a large syphilitic gumma of the pharynx. After an energetic treatment by inunction, recovery of the diabetes took place in less than a month.—*Ann. de Derm.*, 6, 1889.

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## Books and Journals Received.

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Ueber eine ungewöhnliche Art von extra-genitaler Syphilisinfection. Von Dr. Ernst Feibes. [Separat-Abdruck aus "Berliner klin. Wochenschrift," 1889, No. 23.]

Ueber die Wirkung des Perubalsams auf die "idiopathischen" Leukoplakien und sonstigen Epitheltrübungen der Mundschleimhaut. Von Dr. Siegfried Rosenberg. (Aus Dr. Lassar's Klinik f. Hautkrankheiten.) [Sonder-Abdruck aus "Therapeutische Monatshefte," October, 1888.]

Das Chlormethyl als lokales Anaestheticum. Von Dr. Ernst Feibes. [Separat-Abdruck aus "Berliner klin. Wochenschrift," 1889, No. 5.]

Die Acne und ihre Behandlung. Von Dr. Hermann Isaac. [Separat-Abdruck aus "Berliner klin. Wochenschrift," 1889, No. 3.]

Ueber Propeptonurie. Zugleich ein Beitrag zur Chemie des Samens. Von Dr. C. Posner. (Aus dem Laboratorium der Dr. Lassar'schen Klinik in Berlin.) [Separat-Abdruck aus "Berliner klin. Wochenschrift," 1888, No. 21.]

Zur bacteriologischen Technik. Von Dr. Carl Günther. (Aus dem Laboratorium der Dr. Lassar'schen Klinik.) [Sonder-Abdruck aus der "Deutschen medicinischen Wochenschrift," 1889, No. 20.]

Die Cultur-Aufgabe der Volksbäder. Rede gehalten am 18. September, 1888, in der 1. allgemeinen Sitzung der 61. Versammlung deutscher Naturforscher und Aerzte zu Cöln. Von Dr. Oscar Lassar, Berlin, 1889. Verlag von August Hirschwald.

Zum Stande der Syphilisbehandlung. Von Dr. Oscar Lassar. [Sonder-Abdruck aus der "Deutschen medicinischen Wochenschrift," 1889, No. 6.]

Ueber Haarcuren. Von Dr. Oscar Lassar. [Sonder-Abdruck aus "Therapeutische Monatshefte."]

Therapeutische Notizen aus Dr. Lassar's Klinik für Hautkrankheiten und Syphilis. [Sonder-Abdruck aus Dr. Paul Börner's "Reich's Medizinal-Kalender auf das Jahr 1889." Leipzig: Verlag von Georg Thieme.]

Ueber Mycosis fungoides (Granuloma fungoides). Von W. Dönetz und O. Lassar. [Separat-Abdruck aus Virchow's "Archiv für pathologische Anatomie und Physiologie und für klinische Medizin," 116. Band, 1889.]

Histologische Studien ueber Keratohyalin und Pigment. (Aus dem Laboratorium der Dr. Lassar'schen Klinik.) Von Dr. Mertsching. [Separat-Abdruck aus Virchow's "Archiv für pathologische Anatomie und Physiologie und für klinische Medizin," 116. Band, 1889.]

Ueber die Einwirkungen unserer Wundmittel auf den menschlichen Organismus und über ihre Leistungsfähigkeit. (Aus dem Laboratorium der Dr. Lassar'schen Klinik in Berlin.) Von Dr. Emil Senger. [Separat-Abdruck aus von Langenbeck's "Archiv," Bd. xxxviii, Heft 4.]

Ueber extra-genitaler Syphilisinfection. Von Dr. A. Pospelow. [Sonder-Abdruck aus "Archiv f. Dermatologie u. Syphilis," Heft 1 and 2, 1889.]

Beobachtungen über das Ichthyol nach dreijähriger Anwendung. Von Dr. von Hoffmann und Dr. Lange. [Sonder-Abdruck der "Therapeutische Monatshefte," Heft 5, 1889.]

Ueber Ichthyol-Behandlung des Erysipelas. Von Dr. von Brunn. [Sonder-Abdruck der "Therapeutische Monatshefte," Heft 5, 1889.]

L'Acido Picrico negli Eczemi impetiginoidi. Di una Pityriasis nigra da Trofoneurosi. Del Dott. Filippo Cav. Cerasi. Roma: Coitipi di Mario Armani, 1888.

On Unusual Methods of acquiring Syphilis. By L. Duncan Bulkley, M. D. [Reprinted from the "Medical News," March 2 and 9, 1889.]

On the Value of Frequently Repeated Doses of Arsenic in the Treatment of Bullous Diseases of the Skin, especially in Children. By L. Duncan Bulkley, M. D. [Reprinted from the "New York Medical Journal" for April 13, 1889.]

A Clinical Study of Alopecia Areata and its Treatment. By L. Duncan Bulkley, M. D. [Reprinted from the "Medical Record," March 2, 1889.]

Irritation and the Treatment of Ringworm of the Scalp. By Fred. J. Levisaur, M. D. [Reprinted from the "Medical Record," June 1, 1889.]

The Question of the Radical Cure of Deep Urethral Stricture. By Edward L. Keyes, M. D. [Reprinted from the "Medical Record," May 25, 1889.]

Electric Cataphoresis as a Therapeutic Measure. By Frederick Peterson, M. D. [Reprinted from the "New York Medical Journal" for April 27, 1889.]

The Treatment of Nævus by the Intra-injection of Alcohol. By Thomas H. Holgate, M. D. [Reprinted from the "Archives of Pædiatrics," June, 1889.]

New York Cancer Hospital. Fourth Annual Report. For the year 1888.

Observations de rétrécissements étroits du canal de l'urèthre sans fistule ou avec fistule, traités et guéris par la dilatation temporaire progressive. Par M. le Docteur Armand Rizat. [Extrait des "Annales des maladies génito-urinaires" du mois d'Octobre 1888.]

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## Original Communications.

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### PRODROMAL LOCALIZED SYPHILIDES.\*

By HERMANN G. KLOTZ, M. D.,  
New York.

WITH great unanimity the authors of the text-books and hand-books on syphilis agree that, as a rule, the general secondary evolution of syphilis which follows the second period of incubation, about six to twelve weeks after infection, takes the shape of a more or less general affection of the skin. It is true, as Lang says, in his lectures on syphilis, that this exanthem is hardly ever equally distributed all over the body, but, with but few exceptions, the early syphilides are symmetrically arranged over the right and left side, and, even where confined to certain regions, bear the character of a general eruption. I had never met with an exception to this rule until several years ago I made the following observation:

CASE I.—Mr. K., nineteen years of age, whom I had known personally for some time but who had never had any venereal affection, consulted me, on March 9, 1885, on account of a rather painful swelling of the left inguinal ganglia. There existed since about a week several superficial erosions on the frænulum and in the sulcus coronarius glandis, which had made their appearance within a few days after sexual intercourse. These erosions healed under treatment with iodoform within a few days without leaving a scar and without ever showing the slightest induration, but the inflammation of the lymphatic glands soon became more aggravated, and extended to the right side, so that on March 23d both sides had to be lanced, the operation showing a periadenitis. These buboes took a very slow course; dressings were changed every two or three days, so that the patient was under my continuous accurate observation. On April 23d he called my attention to a crust on the left side of the scalp, about an inch and a half

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\* Presented to the First German Dermatological Congress, held at Prague, June, 1889.

above the ear, which he had noticed since a few days on combing the hair. After cautious removal of this brownish-yellow, somewhat brittle crust, I found a crater-like depression, of the size of a split pea, with an ulcerated, dirty grayish surface, surrounded by a partially eroded, wall-like edge, and a zone of dark-red skin, bearing a remarkable resemblance to the ulcerated papulo-pustular lesions which we meet with occasionally on the scalp in the later periods of syphilis. On April 28th, the ulcerated basis looking decidedly worse and the lymphatic ganglia behind the ear and along the neck being enlarged and painful, general antisypilitic treatment was commenced. Nevertheless, between May 15th and 22d, about ten weeks after infection, while the ulcerated papule of the scalp was slowly healing, a general maculopapular syphilide of the usual character made its appearance over the trunk, and otherwise exhibiting, but most prominently on the forehead, numerous partly smooth, partly scaly, lentil-sized papules. About June 8th this exanthem had almost entirely disappeared, and the prodromal lesion of the scalp had healed, leaving moderate pigmentation; but soon a new eruption of an acne-like syphilide made its appearance on the chest and abdomen, followed, in spite of continued energetic treatment, in August by a number of superficial ulcers on the back and the extremities. In its further course the case proved one of the most malignant ones I have met with.

The appearance of this single ulcerated papule was the more unexpected and surprising as up to the time nothing had occurred to arouse the suspicion of syphilitic infection. Still, there could be no doubt about its nature, which was fully confirmed by later symptoms. There undoubtedly existed a localized lesion of the skin, which appeared at the time where usually a general eruption is observed, but in its character was more closely related to the later forms of syphilides, and which finally was followed by a general eruption of no exceptional type.

Being somewhat puzzled by the peculiarities of the case, I searched for similar observation, but at that time without success. The remarkable features of the observation, however, did not allow it to slip entirely from my memory, and I was constantly watching for a similar observation, which, however, did not occur until last fall. On renewed research in literature I found what I had overlooked before—the following passage in Bumstead and Taylor's "Pathology and Treatment of Venereal Diseases," fifth edition, page 559, chapter xi, "Syphilides":

*"Unusual Modes of Evolution.*—The appearance of a general eruption is looked upon as the indication of constitutional infection, but the first eruption may be limited, and a general rash may not be developed for several weeks. In some cases only two or three dermal lesions can be found at the usual date of invasion. Should the eruptions be erythematous, the spots soon become coppery, and remain in a chronic condition; if papular, the papules are sluggish, and usually leave a pigmented spot. In connection with these scanty lesions the patient may suffer from syphilitic pains in the head, in the bones, etc., and perhaps may have erythema



of the fauces and high temperature. Within two to six weeks the usual general eruption follows."

On personal inquiry, Dr. Robert W. Taylor, who seemed not less interested in these observations than myself, assured me that he had not been able to find any remarks on the subject anywhere in literature, and that he had observed a number of such cases. To Dr. Taylor, therefore, I believe, we are indebted for the first observation and description of this unusual development of syphilis. It seemed justifiable to call your attention to the subject on this occasion, because the same does not appear to be mentioned in the German, English, and French literature—not, at least, as far as it was accessible to Dr. Taylor and to myself. Still, it is of importance enough to deserve more general recognition. Without the knowledge of these facts, errors of judgment are particularly liable to occur in relation to the time elapsed since infection, and patient as well as physician may be subjected to very unpleasant surprises.

My second case was as follows:

CASE II.—Mr. G., twenty years of age, never before affected with any venereal trouble, consulted me on November 28, 1888, for an eruption. About four or five weeks ago, immediately after a coitus and about two weeks after a previous exposure, he noticed a small sore on the prepuce, which, under applications of a white powder, probably calomel, healed, but gradually became indurated. Two weeks ago enlargement of the inguinal glands, and a few days ago an eruption, was noticed. The latter consisted of eight flat, slightly scaly papules, distributed over the right side of the abdomen, about two inches above the ligamentum Poupartii, the external coxal, and the lower gluteal region of the same side. A pea-sized, typical induration on the inner surface of prepuce, adjoining the sulcus coronarius, and a number of separate, enlarged, indolent glands in both groins, completed the features of the case. No general indisposition, fever, etc., had preceded the eruption. After a mild treatment with the protiodide of mercury had been commenced, the papules slowly became flatter and smoother, but retained the characteristic coppery appearance. On December 16th, however, a number of distinct syphilitic macules were observed on the abdomen and both thighs, and on December 23d a general roseola of rather large spots had made its appearance over the entire body, showing, particularly on the shoulders and upper extremities, exquisite polygonal forms. After a few injections of the bichloride of mercury, on January 6, 1889, the roseola had entirely disappeared, but the remnants of the previous localized affections remained plainly visible up to the end of January:

These are the only observations which were sufficiently accurate to determine the occurrence of a localized prodromal syphilide. Other cases were met with where, besides a general macular and papular eruption, several more mature papules were found, which proved extremely obstinate and, particularly as to pigmentation, outlasted the general eruption by

months and even years. I have no doubt that at least in some instances these papules had originally been similar prodromal syphilides, but, owing to the late appearance of the patients, this could not be proved with sufficient certainty.

For the following cases I am indebted to the kindness of Dr. Robert W. Taylor, of New York, who furnished me with his notes and allowed their publication :

CASE III (Dr. Taylor).—A man, aged thirty-three, had coitus about June 1, 1871; on the 10th of August he noticed a small, split-pea-sized nodule, with a brownish, necrotic surface on the left side of the frænulum. At the time the inguinal ganglia were distinctly enlarged. (Ulcer had probably existed ten days, certainly not longer; consequently the period of incubation was fully sixty days.) On August 25, 1871, a flat papule of a dark coppery color appeared just over the left eyebrow toward the median line, and a similar one developed on the margin of the umbilicus. Fourteen days from the appearance of these *avant-couriers* a general roseola and constitutional symptoms were observed. The two single papules ran an indolent course, scaled, and left coppery pigmentations, which were very persistent. (This was the first time Dr. Taylor observed this peculiar mode of evolution of syphilis.)

CASE IV (Dr. Taylor).—Female, twenty-five years old, infected between the 4th and 5th of September, 1888, by her husband. On the 5th of September I found a flat, indurated chancre on the inner aspect of right labium majus, extending to the junction with the labium minus. Patient thought the lesion began about the 20th of September, and was afterward under constant supervision. On the 18th of November a small scaling papule began on the right naso-labial sulcus, and a similar one on the neck, at the middle of the anterior border of the right sterno-cleido-mastoid muscle. The ganglia of the body were at the time enlarged, the inguinal to a much larger degree. No other lesion on any part of the body. December 3d, a general roseola, with malaise and severe nocturnal headache. Since, she has had mucous patches in the mouth. The papules on the nose and neck became enlarged, flat, and scaling, and lasted until the influence of mercurial treatment for the general manifestations was felt. They then slowly subsided, leaving brownish pigmentations, which are to-day, April 26, 1889, still faintly visible.

CASE V (Dr. Taylor).—A man, aged fifty-two, had coitus January 24, 1889, followed by indurated chancre on the left side of the penis about February 10th, and ten days later by inguinal adenopathy. On the 26th of March two good-sized conical papules appeared on the wrist over the styloid process of the left radius, and four on the corresponding palm. These ran an indolent course, became scaly, and left pigmentations. Three weeks after the appearance of these prodromal papules a characteristic erythematous syphilide over the whole trunk, and minute papules in the scalp, were noticed. Indurated nodule still present on prepuce.

Besides these cases, Dr. R. W. Taylor has notes of several others similar in the main features, but slightly differing in details. As all the observations communicated here agree very well with the description given

by Bumstead and Taylor, which I have cited above, I have not to add any further remarks. The following table will show the relations of date of infection, prodromal and general eruptions, etc. :

NO.	Time of appearance of primary sore.	Time after infection of prodromal eruption.	Number of lesions.	Character of lesions.	General constitutional sympt'ms.	Date of general eruption.	Character of same.	Date after prodromal eruption.
1 .....	Days. None.	Days. 50	1	Papulo-pustul.	None.	75	Papul.	25
2 .....	20	45	8	Pap.	None.	70	Macul.	25
3 .....	60	85	2	Pap.	None.	100	Macul.	15
4 .....	25	75	2	Pap.	Distinct.	90	Macul.	15
5 .....	20	45	6	Pap.	None.	65	Macul.	20

# INDURATION OF VENEREAL SORES NOT ALWAYS AN INDICATION THAT CONSTITUTIONAL SYPHILIS WILL FOLLOW.\*

By EDWIN C. BURNETT, M. D.,  
St. Louis.

THAT syphilis may follow any sort of sore is well known by those who see much of venereal practice, but that there are sores that, while exhibiting every characteristic of the most typical Hunterian chancre, are not followed by manifestations of constitutional syphilis, is not so well known, or, if known, the fact has not been sufficiently emphasized by those whose duty it is to teach the general profession.

During several years' attendance upon a very large genito-urinary clinic I have seen several instances where the subjects of venereal sores have had develop at the seat of the infection induration which, following as it did the course universally considered peculiar to the hard chancre, I had every reason to believe specific, and I therefore confidently awaited the manifestations of secondary or constitutional syphilis. Some of these cases I had under observation beyond the time during which syphilis usually manifests itself, and I saw no signs of general infection. Three cases from my private practice I saw for a longer time—two for six months, and one, who is still under observation, for sixteen months—without there developing any symptoms of constitutional infection. This case I will relate :

On January 3, 1888, Dr. W. presented himself with sore on penis in sulcus coronarius. He stated that he had intercourse on the 16th of December, 1887, and first noticed sore on the 26th, ten days later, and that it then was only a slight excoriation, but that it slowly increased in size up to the time

\* Read at the third annual meeting of the American Association of Genito-urinary Surgeons, May 22, 1889.

he came to me. He had done nothing for it but keep it clean. The sore by this time was about the size of half a buckshot, with a slightly indurated base. There was a slight non-purulent discharge. The induration increased daily, until ten days later it had quite a hard button for a base and presented the typical characteristics of a Hunterian chancre. The glands in left groin enlarged and hardened somewhat, and became slightly painful on pressure. I was certain that patient had a specific chancre. The only treatment was the application to sore of solution of salicylic acid, gr. x, to  $\frac{3}{4}$  j of glycerin. Saw the patient regularly at intervals of two days. In three weeks from the time I first saw it the sore had healed. Induration gradually disappeared; swellings in groin slowly subsided until at the end of three months the glands were about normal. No signs of general syphilis appeared, and the patient has remained perfectly free from symptoms, though it is now sixteen months since time of infection.

Dr. Bryson has kindly allowed me the notes of a case occurring in his practice, which are as follows:

Dr. W. G. T. had suspicious intercourse on the 22d of January, 1886. Four weeks after, a sore appeared just posterior to corona glandis, on left side. Typical chancre, painless, indurated, oval; semilunar induration on posterior border. Expectant treatment and inspection. Five weeks after its appearance sore completely healed; nothing left except slight induration on the site of ulcer. No evidence of general infection. On March 8, 1886, patient presented himself for inspection; careful examination failed to discover any sign of syphilis. Saw him for the last time on the 1st of June, nearly five months after exposure. No symptoms, and, though I have not heard from or of him since, suppose him to be well, as he promised to report the appearance of anything suspicious.

Kaposi, "Syphilis der Haut," 1882, page 22, note, reports a case as follows:

In April, 1871, a patient came to me with a sore on his prepuce fourteen days old, flat, slightly secreting, and scarcely the size of a lentil, resting upon a typical circumscribed, cartilaginous, massy induration. Patient was treated locally. The chancre cicatrized over, the induration remained, but no general syphilis showed itself. The patient presented himself at regular intervals until September. The induration had by this time disappeared. No sign of syphilis, consequently no treatment. At Christmas, 1871, patient came again with three soft chancres on the inner lamella of the prepuce, which increased in a few days to six or eight: two were in the sulcus coronarius, and two, follicular, upon the glans. Much suppuration. In the third week an auto-inoculated ulcer at the side of frænum showed a moderate induration. While the chancres were not yet entirely cicatrized, about the middle of February, 1882, an abundant maculo-papular syphilide appeared on the trunk, and psoriasis palmaris.

I believe these sores were true Hunterian chancres, though Finger has attempted to explain the occurrence of such induration upon the grounds

that it depends in part upon the arrangement of the blood-vessels in the tissues upon which the sore is seated, and in part upon artificial irritation. I do not believe that either ground will hold in the absence of the syphilitic virus. Induration may recur at the seat of the primary lesion some months after secondaries have disappeared, as in relapsing chancre, and a simple non-specific sore situated upon the person of one already the subject of syphilis may take on induration in every respect identical with that of the hard chancre from irritation by caustics, but I have never yet seen a simple sore upon a person not already syphilitic take on, from artificial irritation alone, that circumscribed, cartilaginous induration so characteristic of the typical chancre.

I believe that the virus of syphilis may become inert in the first stage through some influence which we do not understand. This influence may be yielded by a particular condition of the organism at the time of inoculation, or at a time later, which may change the course of the disease by a modification of the virus itself. We have strong presumptive evidence of a modification of the virus in those sores that precede constitutional symptoms without manifesting induration, in those cases of infection that can not be traced to a primary lesion, and in those cases wherein the secondaries have been wanting, or so slight in their effects that no trace or remembrance of them is to be had.

Another and striking instance of a modification of the virus of syphilis is to be had in the condition, pointed out by Colles, of a woman that has given birth to a child syphilized through the sperm of the father; for, though she shows no sign whatever of having acquired the disease from any source, she is indisputably syphilized, as is proved by the fact that she possesses immunity from inoculation while nursing the child, though its mouth is filled with mucous patches, which are, as you well know, a most virulent source of contagion to a non-syphilitic.

I can see nothing irrational in the premise that these sores were typical chancres, and that, through some influence modifying the virus, the disease was checked in the primary stage; and I therefore conclude that induration of venereal sores, though they be of specific origin, is not always an indication that constitutional syphilis will follow.

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## HEREDITARY SYPHILITIC TRANSMISSION THROUGH TWO GENERATIONS.\*

By EDMUND E. KING, M. D., Toronto University, M. D. C. M. Victoria University, L. R. C. P. London.

THE subject of this paper is so important, and the present state of opinion on it is so unsettled, that I offer no apology in presenting the following case and remarks thereon :

Mrs. G., aged twenty-four, one of a family of nine; none of them in rugged health. One brother dead; he suffered from chronic deafness, and was, as near as I can discover from the history given me, strumous. One sister, married, had several miscarriages, and suffered for some years from severe headaches, sore throat and tongue. Her husband is free from venereal taint. Mrs. G. has never been seriously ill, but has been a sufferer from headaches for some years past; nor had she any skin eruption previous to her confinement, which took place in April, 1887, when I delivered her of twins—boy and girl; the boy, born first, was the larger. He had a perfectly clear skin and well-shaped head and skull-bones; exceptionally prominent forehead. The girl was smaller, and had a pinched face, old expression, and a wrinkled skin, which was covered with a red rash; the cranial bones loose; fontanelles large and gaping. The rash appeared on the boy in a few days, and both children developed severe snuffles; each had a sore mouth in the second week. The mother's nipples became sore and hard in the fourth week. The axillary and cervical glands were indurated and painful. The girl was worse than the boy. Both developed very severe, persistent diarrhoea, and the rash did not fade. The skin of the girl became of a decided copper-color, and in the fifth or sixth week anal condylomata developed on both of the children. Up to this time I had used no specific treatment, trying to believe it was not a syphilitic case. I now put the children on gray powder internally, and applied calomel locally. The diarrhoea improved rapidly and the condylomata decreased in size, while the children, who previously had thrived but poorly, began to pick up in flesh. The girl developed a bullous skin eruption early in July, and died on the 27th of July, extremely emaciated. The expression was that of a very old woman, the abdomen was sunken, and the child presented a horrible appearance. No post-mortem could be obtained. The boy continued to improve under treatment, and when I last saw him, a couple of weeks ago, he was a healthy-looking, bright child, but slow in cutting his teeth. I have examined the father carefully, and catechized him particularly, but can find no trace of his ever having had venereal disease in any form. The skin is clear; the inguinal and cervical glands show no signs of previous induration; the tonsils are normal and healthy, with no signs of cicatrices. Previously he had not lived in the city, and the chance of being deceived in his case is exceedingly small. His history is good, and I do not attribute the

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\* Read at the third annual meeting of the American Association of Genito-Urinary Surgeons, May 22, 1889.

disease to the paternal side of the family. The subsequent history of the mother is of a nature that indicates to my mind the syphilitic nature of the case. In the second month, and in about four weeks after the breasts became sore, a typical rash developed on the body. Secondary symptoms appeared in the mouth and on the tonsils, and her hair kept falling out for some months. All these symptoms disappeared under specific treatment. Since, she had one miscarriage at three months, and is now again pregnant.

It appears quite clear to me that in this case the child, who had inherited the disease from the mother, was the source of re-infection to her, and that a clear exception to Colles's law is established. It is also possible that, if these children had been suckled by a wet nurse, the mother would have escaped the disease and the nurse have been the victim.

This case deals with the children from the moment of birth to the present time, and thus shuts out many of the possibilities of error that otherwise might have presented themselves.

Of other cases, I shall quote first one that was related in the discussion on syphilis before the London Pathological Society, 1876, page 421, of reports by Simon :

A lady, whose father died of hereditary syphilis, herself had a first child which was judged to be syphilitic, and had in her own person some symptoms which were ascribed to the same poison, there being not the smallest possibility of syphilis, as far as could be ascertained, being conveyed to her in any other way than by descent.

Jonathan Hutchinson, in Reynolds's "System of Medicine," edition of 1880, page 431, reports the following case :

A respectable young woman came to me about six months ago on account of an inflamed eye. She had interstitial keratitis in typical form, her teeth were notched, her physiognomy characteristic. She told me she was suckling her first child, an infant of two months. I inquired if it was healthy. She said it was a fine baby and ailed nothing whatever. I asked her to bring it with her at her next visit. She did so, and, on having it stripped, I found it covered with coppery blotches, with condylomata at the anus and snuffles in the nose.

Under subsequent treatment by mercury all these symptoms disappeared. There remains, of course, the source of fallacy that this child's parents, one or other of them, may have acquired syphilis. As to the father, I may state that he has been under treatment for severe sycosis by iodide of potassium, which has had no impression on him, and I have made most diligent inquiry for venereal disease. "I believe thoroughly he never had any." He concludes : "I incline to the belief that we have in this instance an example of the transmission of syphilis to the third generation."

A "Case of Alleged Transmission of Hereditary Syphilis to the Third Generation." Mentioned by Paul and E. Diday in "Dict. Encyclopédia d. sc. méd.," Paris, 1884, vol. cxliii :

In May, 1868, E. Collin was called to see a child who was, it is said, dying from lung disease. His mother had had a miscarriage, then a daughter in good health, and lastly three boys. The first of these is the subject of the observation; the second is in delicate health; the third is in good health. The first boy, born in 1862, very poorly developed, was nourished by his mother. When between eight and nine months old he had a cutaneous eruption, with frequent attacks of bronchitis, constant coryza, and later a series of attacks of capillary bronchitis. After having been kept housed for two years his skin was of a yellowish hue, his eyes sunken, and he suffered from constant flow of nasal mucus. He looked like a little old man. Crepitant, sibilant, and even cavernous râles were noted at apices of lungs, with a corresponding dullness on percussion; cough constant, night sweats, extreme weakness. E. Collin considered the trouble to be of a syphilitic nature, although it was impossible to discover in either parent any syphilitic sign or antecedent. Sulphurous waters were employed in July as a diagnostic means productive of a roseola, then mucous patches on the tongue and anus, and diminution of pulmonary symptoms. The child was then submitted to a mixed treatment with the syrup of biniodide of mercury and iodide of potassium; rapid and great amelioration, which was permanent, resulted.

E. Collin has since learned that the maternal grandfather had died with syphilis. Considering the condition of the children, the cutaneous eruption coming on at the ninth month, the frequency of pulmonary accidents in syphilitic children, the peculiar appearance of the child in question, the possibility of the disease escaping one generation, and the successful use of the specific medication, Collin concludes that the child was born of a mother to all appearances healthy but possessing a syphilitic germ or taint transmitted by her father.

These cases strongly resemble the one I had under observation, excepting that I had the opportunity of seeing the case from the birth of the child, born with unmistakable evidence of syphilis on its person, and of following the subsequent history to date. In analyzing some of the negative symptoms of the mother, I find entire absence of notched incisor teeth, clear physiognomy, no infantile history, and general healthy appearance. The subject of hereditary disease may have all of these symptoms absent.

Jonathan Hutchinson, in Wood's "Monographs," says, page 355: "It must be granted, however, in the fullest manner, that not all or nearly all of those who really inherit a taint betray it either in physiognomy, teeth, or by concurrent disease of suspicious character; and, further, it is precisely in those who do not betray it that we must expect the history of symptoms in infancy to be wanting." Here we have an original investigator of syphilitic teeth and physiognomy putting forth evidence that not in all cases do these symptoms of necessity appear. So some of the negative proofs against my patients disappear. The improbability of second-generation transmission has always been to me anything but clear.



It is, and always has been, difficult for me to comprehend why any diathesis of less virulence should be transmissible through several generations, and that syphilis alone, the severest of all systemic blood diseases known to us, should be unlikely to affect the second and be impossible to affect the third. We take gout, and find it skips one and sometimes two generations, and appears in the third or fourth, but syphilis never! No; I can not accept this matter as settled with the evidence of these cases before us.

Again I quote Jonathan Hutchinson, "Monographs," page 351: "Five, ten, twenty, and even five-and-thirty years without any further indication of its taint, and then may occur some definite and most peculiar affections." It seems to me that so long as this disease is lying dormant but still exists in the parent, any offspring is likely to be affected with the disease to a greater or less degree. It may also lie dormant in that offspring until some opportune time when a condition of the system may arise that is favorable to its development, when it will assert itself in no uncertain way.

I believe in my patient's case that pregnancy was the systemic crisis at which the latent syphilis became active. There is no doubt that the contagiousness ceases in a limited time; but does heredity ever cease?

The literature on the subject is scarce. Dr. J. E. Atkinson reports a case in "Archives of Dermatology," 1876, at considerable length, but in a conversation with him in 1888 he said that, in the light of subsequent events, he was not so positive of the hereditary transmission. Dr. E. L. Keyes, on page 73, "Venereal Diseases," says that he has a case under observation, but in a letter he says that the evidence is not clear in the case.

In the case I have quoted from Paul and E. Diday the discussion was entered into by Diday, Rollet, and Rodit, and the long time—six years—before roseola and mucous patches developed showed that a possibility of subsequent infection from some source was present and made a decided uncertainty in the case.

Dr. Keyes, on the same page (73), "Venereal Diseases," says: "The reason syphilis is not generally transmitted to the third generation is that if the quantity of poison in the child is great and the quality intense the baby does not survive. If it is less powerful, the child overcomes it, throws it off, or at least gets so far in the tertiary stage before it has reached the age at which it can marry and have children that transmission to the third generation is very seldom encountered."

Jonathan Hutchinson says, in his remarks on "Hereditary Transmission," Reynolds's "System," edition of 1880, page 431: "I have repeatedly seen cases, patients of various ages between twenty and twenty-eight, subjects of syphilitic keratitis for the first time. We might conjecture that such persons would be likely to transmit to their offspring some degree of

taint, seeing that the taint is in full activity in their own bodies. About eight cases have come under my own observation in which persons, undoubtedly the subjects of inherited disease, have become parents. With one exception, I have never been able to discover any evidence of disease in the offspring. In several instances the offspring appeared to be in excellent health." The one exception, though, illustrates the possibility of transmission.

J. Nevins Hyde, in the article on "Syphilis," "Reference Hand-book, Medical Sciences," vol. vi, page 701, says: "A few exceptions are reported to this law—so few, so inconclusive, as to rather more establish its general applicability." I can not find the articles quoting these exceptions.

Behrend, in the "*Berliner klinischer Wochenschrift*," 1881, Nos. 8 and 9, pages 107-124, says that all facts go to prove that the so-called law of Colles is not worthy of the name of law. But when answering a vigorous article by P. Diday and A. Dogon, which appeared in "*Annal. de dermatologie et de syphilis*," Paris, 1883, iv, page 79, which defended Colles's law as well established, he said: "The exceptions to the so-called Colles's law are much more important than the law itself—a law which only merits oblivion. Its exceptions alone should be taken into consideration, as they alone fairly merit the name of law."

The conclusions I would draw from the above quoted case are:

1. That the husband is and always has been free from venereal taint.
2. That the mother was previously a healthy woman, now is syphilitic.
3. That no third party could have inoculated the children, especially the girl.
4. That the trouble existing in the children was syphilitic and that antisyphilitic treatment caused the symptoms in the surviving child to disappear.
5. That there is an apparent exception to Colles's law.

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#### FOUR ADDITIONAL CASES OF PHTHIRIASIS PALPEBRARUM.

By J. M. WINFIELD, M. D.

THE stated infrequency of pubic lice infesting the eyelashes has led me to add the following cases to those already reported:

CASE I.—M. C., a boy two years and a half of age, was brought to my office in June, 1884, for a peculiar irritation of the eyelids. On superficial examination, the swelling and crusting resembled ordinary blepharitis ciliaris. The borders of the lids were covered with small, dark scabs, which, on

close inspection with a lens, proved to be lice clinging closely to the ciliary margins, nearly all of them having their heads deeply buried in the hair-follicle. Along the hairs the darker-colored eggs were fastened, resembling a string of minute brown beads. The constant rubbing for the relief of the itching had caused an eczematous condition of the eyelids. On seeking for the source of contagion, I found that the child was in the habit of sleeping with a young man who in the course of a few days consulted me for the relief of pediculi pubis situated in the usual habitat.

The treatment in this case was softening of the crusts and the application of a five-per-cent. ammoniated mercury ointment.

CASE II.—A girl aged eight years consulted me in October, 1888, at my skin clinic in the Long Island College Hospital, for a severe eczema involving both eyelids and eyebrows. This was caused, without doubt, by the scratching for relief of the itching due to the irritation of the lice.

The pediculi were found clinging to the margins of the lids and to the hairs of the eyebrows. In this case the crusts were removed as in the preceding one and a ten-per-cent.  $\beta$ -naphthol ointment applied, which removed the parasite. Afterward treatment was directed to the eczema.

Cases III and IV were kindly contributed by Dr. Samuel Sherwell; these are the only ones he has observed in about twenty thousand cases of skin disease. They were both children, and the lice were found in the lashes only. The appearance was similar to that of all the other reported cases. Treatment was much the same as for pubic lice in other locations. The presence of pediculi pubis in the eyelashes is a comparatively rare affection, although some oculists claim that lice are very frequently seen in this location; but, on reviewing the literature of the subject, this statement does not seem to be verified.

According to Dr. G. E. De Schweinitz ("University Medical Magazine," March, 1889), its existence has long been known, it having been described by Celsus nearly two thousand years ago, and cases were recorded by Scarpa and Chelius. De Schweinitz has been able to collect only ten cases. Hirschberg ("Berlin. klin. Wochenschrift," xix, 1882) met with only three instances in forty thousand cases of eye disease. Two reported by Dupaguet ("Recueil d'ophthalmologie," November, 1887, p. 674), three by Paul Bleicher ("Wien. med. Wochenschrift," 1882, xxxii, p. 976), and only two in more than ten thousand eye cases at the University Hospital.

The books on skin diseases only give this affection a passing notice. A. Balmanno Squire, in Reynolds's "System of Medicine," vol. iii, p. 934, American edition, alone puts stress on the eyelashes being affected by citing a case occurring in a child, and adds "that in children the habitat of the crab-louse is limited to the eyelashes and eyebrows." And from all other accessible reports of cases it is observed that it has only been found in children, presumably because they have no angular hairs except the

lashes and brows. Nearly all of the cases have been noted by oculists, undoubtedly because, the trouble being about the eye, they are more frequently consulted than the dermatologists, which in turn explains the scarcity of dermatological reports of cases.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

**New Text-Books of Dermatology.**—The year 1888 was signalized by the publication of two new English text-books on "Diseases of the Skin." The first was Dr. Allan Jamieson's, published by Young Pentland, Edinburgh, and Dr. Crocker's, published by Lewis, London.

They are alike in price (twenty-one shillings) and very nearly in size, and both are illustrated. Dr. Crocker's must be pronounced the more complete, since it includes notices of rare and foreign diseases, and also treats of the pathology and morbid histology of the skin, illustrated by original preparations. Dr. Jamieson omits all rare diseases and some which can hardly be considered as very rare, while he gives relatively more space to therapeutics than to pathology, and adopts to a considerable extent the methods of Unna. I shrink from the delicate task of giving to either the preference as a whole.

**The "British Journal of Dermatology."**—We have at length an English journal devoted entirely to diseases of the skin and allied subjects—the first since Erasmus Wilson's "Journal of Cutaneous Medicine" came to an end in 1870. It contains original memoirs and an account of current dermatological literature under the title of "Précis," and is edited by Mr. Malcolm Morris, of London, and Mr. H. G. Brooke, of Manchester. The first number appeared in November, 1888, and it is continued monthly. The original articles in the first three numbers are as follows:

"Case of Diabetes Mellitus with Skin Lesions," by Dr. Barlow.

"Two Cases of Symmetrical Purple Congestion of the Skin in Patches, with Induration," by Mr. Jonathan Hutchinson.

"Syphilis and Eczema Seborrhoicum," by Dr. Unna.

"On the Value of the History in Diagnosis of Tertiary Syphilides," by Mr. Marmaduke Shield.

"A Case of Primary Syphilitic Sore on the Cheek," by Mr. William Anderson.

"A Case of So-called Xanthoma Diabeticorum," by Dr. Cavafy.

Arrangements have been made between the editors of this journal and of the "Monatshefte für Dermatologie" by which the original articles sent to either journal may be at once translated and published in the other, unless the author expresses a direct wish to the contrary.

This arrangement will doubtless add to the value of both journals and will

aid in developing that international comity in matters of science which is so pleasing a feature of modern scientific progress.

**Skin Lesions in Diabetics.**—Dr. Barlow's and Dr. Cavafy's papers both refer to a remarkable and definite skin lesion found in some cases of diabetes mellitus which has some resemblance to ordinary xanthelasma, but differs therefrom (as both authors agree) in many notable ways. They both think it should be called rather lichen diabeticus, though in Dr. Crocker's recently published text-book it is classified as xanthoma diabeticorum.

Dr. Barlow's case was that of a man aged twenty-six, with well-marked saccharine diabetes. The skin lesions are thus described:

In the skin of the abdominal wall, on the front and sides of the thorax and also on the back, were situated a large number of broad, flattened papules and tubercles. They were most abundant on each side of the sternum. The average size was that of a split pea, but there were some one third of an inch in diameter. They were round, sharply circumscribed, and very little raised above the surface of the skin; they were, in fact, like firm, solid disks imbedded in the skin proper, not attached to deeper structures, so that they could be pinched up with the skin, but the skin could not be rolled over them. There were no dilated vessels over them, nor any sign of inflammation, nor any central spot or vesicle. The color of the skin over the spots was quite unchanged. There were no such lesions on the limbs, the eyelids, or other part of the face, or in the mouth.

The spots were said to have first appeared two years before; but many had come, had enlarged, and then disappeared, to be followed by others.

Dr. Barlow refers to similar cases previously recorded. The first is mentioned in Addison and Gull's original paper on "Vitiligoidea," now called xanthelasma or xanthoma, where the patient was the subject of diabetes, not of jaundice, and the eruption was at first of a lichenous character, consisting of scattered tubercles with colorless shining papules. Another case in a diabetic was described by Dr. Bristowe, in the "Pathological Transactions" for 1886, as "a rare form of keloid"; and another, described by Mr. Malcolm Morris in the same "Transactions" for 1883, as xanthoma tuberosum in a diabetic. To these are added a case recorded by Gendre in his thesis on xanthelasma, and two unpublished cases seen by Dr. Colcott Fox and Dr. Cavafy, the latter of which is noticed below.

Comparing all these cases, Dr. Barlow comes to the conclusion that the skin lesion in his case, notwithstanding the absence of yellow pigment, belongs to the same class as those which have been called xanthoma diabeticorum (as in Dr. Crocker's recent text-book), that the presence of yellow pigment is adventitious and not essential, and that the name xanthoma is not justified, while that of lichen diabeticus, tentatively suggested by Dr. Crocker and Dr. Sangster in a report on Mr. Malcolm Morris's case above referred to, is preferable. The histology of those cases which were examined was also somewhat different from xanthoma.

Dr. Cavafy's case is described in the third number of the "British Journal of Dermatology." It was that of a man aged forty-five, who suffered from an eruption of five years' duration consisting of groups of papules and nodules, not exceeding a split pea in size, mostly bluntly rounded, but some more

distinctly flattened, very hard to the touch. The color of the lesions was a pale buff at the apex, gradually passing to dull red as the base is reached, and seated on a hyperæmic basis. The best-marked patches were on the backs of the hands, but similar groups were seen on the backs of the wrists and fore-arms, most marked on the elbows; and more scattered patches on the knees, ankles, and feet. The skin eruption became so inflamed and painful that the patient had to give up his employment, that of a post-office clerk. In this case it was stated that the patient had had diabetes, but while under Dr. Cavafy's care there was no sugar in the urine, though there was more than a trace of albumin.

Dr. Cavafy agrees that the affection is rather of an inflammatory character, and more suitably called lichen diabeticus than xanthoma.

However, the case was so unlike Dr. Barlow's in some respects that Dr. Cavafy felt some hesitation in including both under one heading.

It is clear that this is a rare and remarkable affection, occurring chiefly, if not exclusively, in diabetics, and probably distinct from xanthoma. Further observations on the skin lesions of diabetic patients may throw more light on the question.

**Symmetrical Purple Congestion of the Skin.**—Mr. Hutchinson's two cases of this affection both occurred in vigorous elderly men, one of whom suffered from gout.

The patches were in both cases of a deep purple tint clearly due to venous congestion, on the legs, hands, and fingers. The first case is already figured in Mr. Hutchinson's "Illustrations of Clinical Surgery" (Plate VIII and page 42). The skin was considerably thickened under the purple patches.

The second case was one of greater severity. Purple venous patches were observed on the backs of the hands, not the fingers (thus differing from Reynaud's disease), without any thickening. On the ankles and dorsal surfaces of both feet, however, where there was a similar discoloration, the skin was considerably thickened, hard, and board-like. The same characters were seen in patches on both aspects of the knees, the fronts of the wrists, and backs of the elbows.

The change began on the back of the right hand, and was attributed by the patient to a deep incised wound involving the bone and joint which had occurred ten years before and had resulted in ankylosis. For four or five years the conditions had been slowly spreading and developing in symmetrical situations.

Mr. Hutchinson was unwilling to give any name to this curious malady or express any opinion as to its nature. He had never seen any representation of a similar condition, except in the collection of pathological drawings in the University Museum at Christiania, where he had been shown by the late Professor Boeck a drawing of a hand closely resembling that of the first case.

**Mr. Anderson's Case of Primary Syphilitic Sore of the Cheek** refers to a formidable mass, about two inches in diameter, under the right eye of a healthy man and is represented by a figure. The history was that the patient had an abrasion of the skin from a blow, and a friend who was found to be suffering from mucous tubercles of the mouth volunteered to suck the

wound, with the result that three weeks later a typical chancre developed which was followed by constitutional symptoms.

**Leprosy.**—Dr. Beaven Rake, superintendent of the Trinidad Leper Asylum, has published a "Report of Cultivation Experiments and Inoculations with the *Bacillus Lepræ*."

The experiments are classified as (1) experiments in nutrient media, (2) in living animal tissues, and (3) in putrescent substances.

The experiments in nutrient media were sixty-five in number. The media used were blood-serum, serum from the chest, abdomen, and tunica vaginalis, and the same mixed with agar-agar and gelatin in various proportions. The serum used was taken from leprosy patients, as being possibly specially favorable to growth of the bacilli, and the tubes were kept at the ordinary tropical temperature, having a daily average of 79° F. Growths of several species of cocci and bacilli were observed, doubtless due to contamination, but in no case was any growth of the *Bacillus lepræ* observed.

Some cultivations were made from the tubercular nodules of the lungs often found in lepers, in order to test the question whether these are due to the *Bacillus lepræ* or to that of tubercle. The results were negative, as no growth of either bacillus was obtained.

Twelve experiments were made of inoculating leprosy materials into healthy animals, which were in continuation of forty-two similar experiments published about two years ago. The animals experimented upon were dogs, cats, fowls, and one macaw, the materials being inoculated under the skin, in the abdominal cavity, and the anterior chamber of the eye. As in previous experiments, no growth of the leprosy material or multiplication of the bacilli were obtained. One dog was kept under observation for nearly four years before it was killed, but no nodules were found either at the seat of inoculation or in any of the viscera. Fowls were also fed with leprosy materials—namely, tissues and pieces of viscera, including phthisical lungs from lepers—but none of them developed either leprosy or tuberculosis. This the author regards as some evidence that the lung lesions of lepers are not true tubercle produced by the *Bacillus tuberculosis*, since it is well known that animals have often become tubercular by eating tubercular material.

The third series of experiments—on growth of leprosy bacilli in putrescent substances and in earth—was made to test the conclusions of Arning, who found that the bacilli in putrefying leprosy tissues held their own against other micro-organisms, being met with so abundantly and so laden with spores as to suggest actual increase, and being found apparently unaltered in bodies which had been buried three months.

Beaven Rake tested the question by keeping blood and serum of lepers in closed vessels, by keeping portions of leprosy tissue in putrid blood or serum under the same conditions, and also by burying leprosy tissues.

In the first two series of experiments the results were entirely negative, nothing being found after some weeks or months but bacilli staining imperfectly with magenta, and evidently putrefactive bacilli. In the case of one of the buried masses bacilli were found in the tissues and at some distance from them in the earth, which presented the color reactions of the *Bacillus lepræ*, but were thought to be too large for that organism.

Beaven Rake can not, therefore, agree with Arning as to the resistance of leprosy bacilli to putrefaction, still less that they have any power of germinating in putrescent substances or in the earth.

These researches were assisted by a grant from the scientific committee of the British Medical Association. ("British Medical Journal," 1888, vol. ii, p. 215.)

**Leprosy in Schools.**—An important question was lately raised in a Scottish law court—whether a boy affected with leprosy was unfit to associate with others, and could be rightly dismissed on that ground from the school, Fettes College, where he was a boarder. The facts were that the boy was a leper when he entered the school, though the disease was dormant. It broke out at intervals afterward, but the head master, unwilling to injure the youth's prospects, took no notice of it till there was an outbreak of another disease, eczema, among the pupils. It was then thought necessary to take action in order to save the other boys from acquiring leprosy by contagion, and accordingly the unfortunate leper was dismissed. His friends, however, brought an action for wrongful dismissal, and the question thus came before the court. It was argued on behalf of the boy that leprosy was not contagious. The judge, without pronouncing an opinion on this point, held that the existence of such a disease in the midst of a community of boys was calculated to create such terror as to impair the usefulness of the institution, and therefore that the head master, supported by the governors of the school, was justified in sending the boy away.

**Lupus of the Upper Respiratory Tract with Tumors of the Larynx.**—Dr. Scanes Spicer described a remarkable case of lupus producing obstruction of the nostrils. The patient, a girl of eighteen, had suffered for eight years from lupus of the face, which had covered the cheeks, nose, lips, and both eyelids on both sides. It had further destroyed the lateral cartilages and triangular cartilage of the nose, thus causing the soft parts to fall together, and producing nasal obstruction, buccal respiration, and great annoyance from the filling of the nasal passages with dry crusts. There were lupous ulcerations and granulations extending along the floor of the nose, but there was no affection of the pharynx or any other part except the larynx, in which were two symmetrically placed tumors, situated on the ventricular bands just behind their anterior attachment. They projected about one sixth of an inch over the vocal cords at phonation, but did not touch them, and at deep inspiration could hardly be distinguished. There were no laryngeal symptoms. In order to allow of breathing through the nostrils, Dr. Spicer scooped out all the nodules that could be seen and inserted into each nostril a cannula formed out of a quill, surrounded with lint and iodoform ointment. This permitted nasal respiration and gave great relief. The laryngeal tumors were not interfered with. ("British Medical Journal," September 15, 1888.)

**Grouped Comedones.**—Dr. Thin describes ("Lancet," October 13, 1888) cases of adults in whom well-defined tracts of skin on the face and scalp became the seat of a profuse development of comedones, giving the part a dirty-black appearance, so that at the distance of a few yards the person affected looks as if a piece of charcoal had been applied to the part.

Three cases are described, all occurring in perfectly healthy, active men,



not negligent in the matter of cleanliness. In one, of which a diagram is given, the black spots were arranged with almost perfect symmetry in groups, under both eyes on the summits of the cheeks, on both temples, and in the fold descending from the ala nasi on one side. There was no inflammation around the sebaceous plugs, which caused no inconvenience except that arising from their disfiguring effect. They were easily cured by friction with soft soap and rubbing in sulphur ointment.

Dr. Radcliffe Crocker had previously described ("Lancet," April 19, 1884) groups of comedones occurring in children, on the forehead, occiput, and sometimes on the cheeks, apart from the usual seats of acne. [Several such cases were observed in London in 1884 and subsequent years, some of which were shown to the Dermatological Society. One thus exhibited by the present writer was described by him in the "St. Thomas's Hospital Reports for 1884."]

But, apart from these cases of comedones in children, Dr. Crocker reports ("Lancet," October 27, 1888) two cases of the same character as those described by Dr. Thin, and the diagrams given are precisely similar to his. They both occurred in women.

Mr. Verrall, in the same journal, mentions the case of two boys, brothers, aged ten and eight, each of whom had a circular group of comedones on the forehead.

**A Novel Hair Disease (Acne Mentagra?).**—Dr. Rushton Parker describes a peculiar affection of the hairs of the beard in a man aged thirty-five, who has been under observation for ten years. At intervals of a few months he becomes suddenly aware of a tingling spot somewhere on the chin, where he always then finds a small tubercle, from which he extracts a number of diseased hairs, thus obtaining immediate relief. These hairs differ from their neighbors in many important points: they are extracted with very great ease, the operation giving relief instead of pain; they are often surrounded by a glutinous cylinder of root-sheath, and occasionally by a speck of pus outside this; they often have one or two white joint-like spots in their course, at which they easily break off. The ends are always split up longitudinally into a brush of from two to six segments, which may extend only down to a point or nearly to the root; the unsplit part easily splits artificially. The patient is greatly relieved by completely denuding a patch varying in size from a split pea to a three-penny piece. During the next few days the tubercle quite subsides, and for several months recurrence at that particular spot is most certainly warded off, though others in the neighborhood or at a distance may perchance be similarly attacked. The patient has been free from every skin disease except this, to which he has been subject from youth, sometimes in a severe and indurated form. With vigorous exercise the acne almost disappears, and at the same time the affection of the beard becomes much less or vanishes. A sedentary, studious life brings back the acne, and also almost invariably a speck or two of this trouble in the beard. Diligent search brought to light no parasite. The affection had no resemblance to non-parasitic sycosis, except that, being a follicular inflammation, it showed the glutinous root-sheath and pus. On the whole, it appeared to be simple acne of the chin, with a remarkable condition of the hairs not hitherto recog-

nized. A woodcut of the split hairs is given. ("British Medical Journal," December 15, 1888.)

[Having had, through Dr. Parker's kindness, an opportunity of examining the split and broken hairs, I may say that their appearance is very remarkable, and quite accords with his description.—REP.]

**Affection of the Scrotum resembling Paget's Disease of the Nipple.**—Dr. Radcliffe Crocker showed to the Pathological Society specimens from a case of skin cancer of the scrotum and penis which at first presented appearances similar to those of Paget's disease of the nipple.

The disease began with superficial ulceration on the anterior part of the scrotum and under surface of the penis, somewhat resembling eczema, but very sharply defined, and the excoriation was evidently deeper than an ordinary dermatitis. It resisted treatment, and two nodules appeared, which were evidently malignant growths. The whole was removed by operation, and showed a structure composed of alveoli with small epithelial cells like rodent ulcer.

In the discussion which followed, Mr. Godlee quoted a case of rodent ulcer in which nodules were observed. Sir James Paget, who was the president of the meeting, made some remarks, but without committing himself to a definite opinion whether or not the case was one of the disease called by his name.

**Cutaneous Affections in Graves's Disease.**—Mr. F. W. Burton reported to the Cambridge Medical Society two cases of exophthalmic goitre, a disease said to be particularly common in the neighborhood of Cambridge, probably in consequence of the prevalence of anæmia and rheumatic fever.

In the first case, that of a woman aged forty-six, there were the usual symptoms of the disease, and, in addition, pigmentation of the skin resembling that of Addison's disease. It was almost exactly the tint of dirty skin, and was most marked about the face, the neck, the axillæ, the back, especially at the waist, the genitals, below the knees where the garters pressed, and below a ring on her finger. The urine was found to contain a pigment apparently identical with the so-called "hæmatoporphyrin" described by Dr. MacMunn as being present in Addison's disease. The precipitate obtained from the urine by acetate of lead was dissolved in absolute alcohol, acidulated by sulphuric acid, and this solution, examined with the spectroscope, showed a dark band from forty-eight to fifty, the position described as characteristic of acid hæmatoporphyrin. The same fluid rendered alkaline exhibited a greenish fluorescence, and with the spectroscope answered to the characters of alkaline hæmatoporphyrin.

Mr. Burton referred to other cases of exophthalmic goitre in which some of the symptoms of Addison's disease had been observed.

In another case of exophthalmic goitre there was urticaria, which came out every morning and lasted an hour or two.

**Circumscribed Scleroderma.**—Dr. Biss reported to the Clinical Society a case of this disease. The patient, a girl aged fifteen, suffered from congenital stenosis of the pulmonary artery, shown by characteristic physical signs, but had had no other important illness. Four years before the date of the observation a whitish indurated patch appeared on the outer side of the right arm a

little above the elbow, which had gradually extended up to the shoulder, following, roughly speaking, the course of the musculo-spiral nerve. Vascular mottling was observable around the indurated patch and pigmentation like that of a fading bruise, especially at the upper (nearest) part. Occasional itching had been felt in the affected region, with frequent cramp-like pain running down to the fingers, and on a few occasions flexor spasms of the index-finger and thumb. The muscles adjacent to the skin lesion were much wasted, especially the deltoid and triceps, and some wasting, though to a much less degree, had taken place in the extensor muscles of the forearm. No other portion of the skin in any situation was altered. Tactile sensibility was preserved in the affected area, and all the motions of the affected limb were easily and perfectly performed, though the grasp of the hand appeared somewhat weaker when compared with its fellow. The faradaic excitability and galvanic reactions of the muscles were unaffected, notwithstanding their atrophy.

Treatment by arsenic, galvanism, and massage proved of no avail.

The remarkable point in this case was the association of sensory and, in a slight degree, of motor nervous phenomena with the skin affection. The author attributed the muscular wasting to the pressure of the sclerotic tissue upon the nerves, blood-vessels, etc., of the affected parts. He also sought to bring the disease into relation with rheumatism, attributing it in some instances to the influence of cold and wet.

This hypothesis was not accepted by Mr. Hutchinson, who quoted several other cases of scleroderma; and, indeed, there was nothing in Dr. Biss's case specially to support the theory of any connection with rheumatism.

**Anomalous Skin Eruption.**—Mr. Hutchinson showed to the Clinical Society on December 14, 1888, a case of disease which he believed to be allied on the one hand to Kaposi's disease (scleroderma pigmentosum), and on the other to that which he (Mr. Hutchinson) calls *prurigo æstivalis adolescentium*, though very different from what is usually known as *prurigo*.

The patient had been under observation from the age of eight to twenty. His disease had begun at two years old. It consisted of vesications, which ulcerated and left scars, and had always been remarkable for its tendency to relapse in summer. It was most severe on the ears, but affected also the whole face, the backs of the hands, and occasionally sparingly the whole body. It had never been cured, but usually got well in cold weather. The attacks had, independently of treatment, gradually got less and less severe, and had finally ceased. The lad had now been for more than a year nearly well, but his face was scarred all over, as if from small-pox, and his ears were reduced to gristle covered by thin scar. Through the whole duration of the skin disease the health had been good. Essentially it was an example of a vesicating inflammation produced by exposure to the sun or by hot weather.

Mr. Hutchinson thought it very closely allied to a disease which he had described many years ago as *prurigo æstivalis* or *prurigo adolescentium*, consisting of vesications appearing in hot weather, chiefly on the face and ears, and leaving permanent scars. But it had also, he thought, some alliance with Kaposi's disease, though differing from that in having no tendency to produce pigmentation or freckles and no tendency to new growth. Without

contending, therefore, that it was at all identical with Kaposi's disease, it furnished, he thought, a connecting link between that and other diseases.

[The disease described by Mr. Hutchinson as prurigo æstivalis is occasionally seen in London, and one or two cases have come under the care of the present writer. Probably very few dermatologists would admit that it has any relation to prurigo, as generally understood; but it is a definite and peculiar form of disease. The present case would seem to be a very extreme form of it.—REPORTER.]

**A Certain Cutaneous Affection in Diabetes.**—Mr. Davies Price ("Lancet") gives two cases of diabetes in which, besides nerve disorders pointing to the existence of peripheral neuritis, there was also present in both feet a condition of the skin which he describes as "erythematous œdema."

In the first case there had been for three years pains of a lightning and burning character. These pains rapidly increased, the burning sensation being almost unbearable, till the left foot presented a peculiar erythematous and œdematous condition over the whole of the external portion of the sole. It was especially swollen and painful over the heads of the fourth and fifth metatarsal bones. There was also a painful and discolored spot over the plantar aspect of the left great toe. The right foot presented a similar condition of erythema and œdema, but in a less degree. This condition continued to increase for a period of three weeks, when it attained its height. During this time the dark spot on the left great toe had increased in size and become extremely painful; it became depressed in the center, and was surrounded by a distinct anæsthetic zone, so that it appeared as if a perforating ulcer were about to be formed. Under the influence of morphine and anti-pyrine the glycosuria diminished, and at the same time the nervous symptoms and the erythematous condition disappeared.

In a second case, that of a man aged fifty-eight, there was diabetes apparently of two years' duration, with symptoms, as in the other case, referable to neuritis. Both feet presented the same condition of erythematous œdema as in the first case. Here also the diabetic condition was improved by treatment, and at the same time the nervous and erythematous symptoms disappeared.

The author concludes that in both cases the skin lesions were dependent on a peripheral neuritis, caused by the diabetic condition, this neuritis affecting the sensory, vaso-motor, and trophic nerves. Several authors—*e. g.*, Ziemssen, Worms, and Buzzard—have described what they believe to be a peripheral neuritis in diabetic patients.

J. F. PAYNE.

LONDON, June, 1889.

#### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**The Question of Lichen Ruber.**—We have read in France with the utmost attention the works which you have recently published in America upon the question of lichen ruber, and we are persuaded that you describe under that name a disease which we have long known at the St. Louis Hospital under the name of pityriasis rubra pilaris. We agree with you that it is an affection entirely distinct from lichen planus, and since we know how to diagnose it we have not believed that it had any affinity with the latter derma-

tosis. During his stay in Paris last year Unna, of Hamburg, saw examples of this pityriasis rubra pilaris; he recognized the fact that it was a special disease, *sui generis*, distinct from the lichens; and in any case is not his *lichen ruber acuminatus*. All these questions have been already treated of and discussed by me in a memoir that I published in the "Annales de dermatologie" of 1886. It is much to be desired that we should once for all have the denomination of this cutaneous affection settled. Dr. Besnier has just published an article in the "Annales de dermatologie" which is most complete and which constitutes a masterly description of this affection based upon numerous cases already known of or unpublished. In relation to treatment, he insists on the fact that arsenic has never given him good results, and believes even that in some cases this drug can be the cause of certain exacerbations.

He knows of no efficacious internal treatment for this disease. On the other hand, much can be done by external applications, although the effects of various drugs are quite different in different cases. This is how the author mentioned speaks of the therapeutic indications: "Internally, arsenic under restrictions, cod-liver oil in some cases; externally, baths as often repeated and as prolonged as possible, inunctions of fatty substances, glycerins, and oils, to which are added salicylic acid or menthol, as antipruriginous remedies. If the disease is generalized or very extensive, frictions with soaps or ointments containing naphthol, salicylic acid, or pyrogallie acid, preparations of oil of cade, and cod-liver oil. If the disease is localized, prolonged applications of various plasters, such as those of oil of cade, pyrogallie acid, cod-liver oil, mercurial plasters, Vigo plaster, Vidal's red plaster, etc., medicated gelatins, etc."

**The Question of Dermatitis Herpetiformis.**—I have just seen Professor Duhring, of Philadelphia, as he passed through Paris, and we talked for some time about his conception of dermatitis herpetiformis. I was enabled to show him, in the service of Professor Fournier at the St. Louis Hospital, a patient suffering from this dermatosis who was at the same time affected with paralysis agitans. Professor Duhring at once recognized and diagnosticated the case as a typical instance of dermatitis herpetiformis. That which he has described under this name is then, without doubt, the affection which Hardy knew by the name of *pemphigus diutinus pruriginosus*, and which Bazin called *Hydroa bullosum* and *pemphigus arthritique*, and which I have called *dermatite polymorphe prurigineuse ou douloureuse chronique à poussées successives*. I was most happy to learn from the mouth of Professor Duhring himself that he believes that Kaposi's impetigo herpetiformis is not the same disease as dermatitis herpetiformis. I had thought I understood from the numerous publications of your dermatologist that the opposite view was held, and I had protested against this opinion in my works on the subject. Indeed, it was with pleasure that I found we are here almost wholly in accord with the Philadelphia professor on this difficult subject of bullous eruptions.

**La Piedra.**—Dr. Juhel Rénay has completed a most interesting study on an affection known in Colombia under the name of *piedra* and which he proposes to call trichomycosis nodosa (*trichomycose nodulaire*).

It is well known that this disease is objectively characterized by the existence upon the hairs of little elevations or knots of a lighter color than black hairs, and having no regularity of distribution, smaller than nits, and forming around the hair a complete or incomplete bead. The hairs thus affected become similar to those of lanugo, woolly, and curled up. When seized between the fingers the sensation of small nodules is plainly appreciable, as they are felt here and there along the shaft of the hair. Histological examination has enabled Dr. Juhel Rénoy to determine that these nodosities are formed by a considerable agglomeration of very refractive spores glued together by a greenish-yellow material constituted by compact colonies of rods. The diameter of the spores is about one one-hundredth of a millimetre. They are thus seen to be larger than those of trichophytosis. The rods which compose the glue-like material seem to have nothing to do with the mycelium, which is indeed rarely seen, and is small as though atrophied upon the hairs, but develops rapidly in cultures. The parasite does not penetrate into the interior of the hairs, but is wholly exterior. These results of the histological examination permit us to affirm that the *pedra* is a contagious disease and that the radical treatment *par excellence* should consist in cutting the hair short. Dr. Juhel Rénoy has not as yet had sufficient experience with the various parasiticides to be able to recommend them.

**Treatment of Phthiriasis Pubis.**—In one of the weekly meetings of the physicians of the St. Louis Hospital the question of treatment for pediculi pubis was discussed. Dr. Besnier remarked that it is an easy matter to get rid of pediculi vestimenti, and even of lice in the head, while those which inhabit the pubic region are relatively difficult to destroy. An excellent method consists in giving a bath of an hour's duration, the water containing ten grammes of corrosive sublimate which has been dissolved in alcohol. The old-time frictions with mercurial ointment have been almost entirely abandoned, because of the irritant phenomena to which they may give rise. When gray ointment is employed it is best not to leave it upon the skin for more than two hours, for fear of producing an erythema, pustulation, and salivation. At the present time it is preferable to apply morning and night for two or three days a lotion containing corrosive sublimate dissolved in alcohol in the strength of 1 to 200 or 1 to 300. The hairs are then to be washed with hot vinegar, and the nits, thus softened, are readily removed with a fine comb. It is furthermore necessary to exercise a close scrutiny for several days to prevent a recurrence. Dr. Hallopeau employs only frictions with camphorated alcohol for the cure of all forms of pediculi. In three days he thus secures a complete cure. Professor Fournier insists in his clinics upon the frequency of pediculi pubis in the lower classes, where their presence is almost always ignored, showing how little itching they occasion in the majority of cases. As soon, however, as we inform the patients of their condition they are, on the other hand, much annoyed by the itching. Another topical application in phthiriasis and in pruritus is phenic acid.

**The Use of Phenic Acid in Pruriginous Dermatoses.**—Dr. Augagneur and one of his pupils have just brought into prominence the excellent properties of this agent in the majority of pruriginous dermatoses. They employ it in-

ternally in the form of pills or syrup in daily quantities of from twenty to fifty centigrammes in infants, from fifty centigrammes to one grain in adults. They have shown that it constantly ameliorates the various itching eruptions and the dry and lichenoid forms of eczema. I must confess that I have entirely failed in many cases of pruritus in which I have tried phenic acid internally, particularly in a patient suffering from rebellious pruritus scroti, whom I vainly treated for a long time with pills of phenic acid. On the other hand, I am aware that phenic-acid lotions, phenic-acid ointments of one part to thirty or sixty of excipient and phenic dressings (cheese-cloth wet with a solution of phenic acid, 1 to 100 or 1 to 50, and covered with adhesive plaster or rubber cloth) constitute excellent local means of combating rebellious pruritis. It is the same with the essence of peppermint, which is being much used at the St. Louis Hospital and which I have myself extensively employed. Incorporated in pomade, 1 to 30 or 1 to 50, with oxide of zinc, or in plasters containing oxide of zinc or cod-liver oil, this substance occasions in many cases an almost immediate relief from the itching. We must, however, be on the lookout for its irritant action, for there are certain persons whose skin becomes at once inflamed when this substance is brought into contact with it. Furthermore, I have seen in the same patient the oxide-of-zinc ointment, to which mint essence had been added, produce an inflammatory eruption about an eczema of the buttock, while it cured the eczema upon the back.

**Treatment of Tuberculous Ulcerations.**—For some time we have been experimenting in France on a large scale with lactic acid in the treatment of ulcerations of a tuberculous nature. This substance has a really surprising effect in tuberculous ulcerations of the mucous membranes. They are cauterized from time to time with the lactic acid, either pure or diluted one half with water, and cicatrization is sought to be rendered more active by frequent applications of camphorated naphthol. Although healing is still very slow and requires weeks and months to be accomplished, this therapeutic measure deserves to be recommended, for it is simple and easy of application. Dr. Rafin, who has just written upon this subject, employs a solution of the acid in eighty-per-cent. strength—that is to say, he adds twenty grammes of water to eighty grammes of lactic acid. I employ, according to the sensitiveness of the patient and the region to be treated, either the acid in its purity, thus securing a caustic and quite energetic action, which is at times quite painful, or I dilute it with one or two parts of water.

I have experimented, after several other dermatologists, with lactic acid in lupus, and here are the results of my experience: In lupus of the mucous membranes the effects are excellent. I believe that it is well to favor its action by lightly scraping the surface or scarifying the diseased area, then the same day or the next to apply the lactic acid. The galvano-cautery can also be used, but in this case there should be a longer interval before the acid is applied. For lupus of the skin, if it is the ulcerating form, the lactic acid can be applied at once, but in non-ulcerating lupus it is indispensable to practice scarification beforehand, or at least scraping or cautery to lay bare the tissues so that the acid may work energetically. In cases of deep-seated, long-standing lupus accompanied with a noticeable thickening of the skin it

has seemed to me that lactic acid had a certain useful effect and favored the removal of the diseased tissues. In cases of recent lupus, characterized by a few isolated grouped tubercles, the lactic acid applied after scarification hastens the cure, but it leaves depressed cicatrices, which are noticeable, although without the least keloidal tissue being present, a result which would not be had if scarifications had been employed alone or combined with subsequent applications of Vigo plaster. In a word, lactic acid is a most precious agent in the treatment of true tuberculosis and of lupus of the mucous membranes; it can also render great service in cutaneous tuberculosis and in ulcerating lupus of the skin; but it must be employed with caution in recent lupus upon exposed and prominent portions of the surface, as, for example, the nose. The results in these cases are apt to be inferior, so far as the cicatrices are concerned, to those obtained by linear quadrilateral scarification combined with Vigo plaster.

**Epithelial Vulvitis.**—For several years Dr. E. Besnier has insisted in his clinics upon an affection of the vulva which is quite comparable, so far as aspect and nature are concerned, to leucoplasia buccalis. He gives it the name epithelial vulvitis. It is characterized by bluish plaques with fissures, epidermic exfoliation of white tissue, which occupies a part only of the whole extent of the vulva. It is usually accompanied by intense pruritus. It may come to be transformed into epithelioma, especially if the region affected is subjected to incessant irritation of whatever nature, and especially to therapeutic intervention of a faulty kind. Dr. Besnier advises antiseptic washes after each act of urination to prevent irritant contact of urine; then the application of a paste of oxide of zinc—for example, oxide of zinc, starch,  $\frac{1}{2}$  gram, 50; cocaine, gram. 1. The lips of the vulva are separated from each other with absorbent cotton. If the lesions are already plainly papillomatous and circumscribed, their complete destruction should be effected by means of the electro-cautery. If it is generalized, we must content ourselves with frequent washings and antiseptic applications. I will recall the fact that the most rational and the more efficacious treatment for leucoplasia of the mouth consists in the removal of all sources of irritation from the mucous membranes and frequent washes with Vichy water or with a solution of borate of soda, and applications from time to time of salicylic acid in concentrated alcoholic solution, or of chromic acid. Could not the same means be tried in epithelial vulvitis?

**Syphilitic Alopecia.**—Here are the various means of treatment in use in France for syphilitic alopecia, which one is often called upon to cure: Dr. Mauriac practices every second day applications of a lotion containing a gramme each of bicarbonate of soda and borax in three hundred grammes of distilled water. On the intervening days he applies a little of the following ointment: Beef marrow, 30 grammes; sulphate of quinine and fūrpeth mineral, each 50 centigrammes. Dr. Besnier has the hair cut short and the head washed each morning with hot water and anointed with the following pomade: Salicylic acid, 2 grammes; precipitated sulphur, 10 grammes; lanoline and vaseline, each 50 grammes. At night the head is rubbed with essence of rosemary, 100 grammes, and tincture of cantharides, 10 grammes. Finally, if the hair is very oily, no pomade is used, but after the washing a pow-



der is applied, consisting of salicylic acid, 1 gramme, and starch, 100 grammes. Where there is much seborrhœa I advise Dr. Besnier's treatment, but in ordinary cases I obtained good results from the following, which is more simple and more logical : Morning and night I order a friction of the scalp with a 1-to-500 corrosive-sublimate solution, and for the night a little turpeth mineral ointment, 1 to 30, to be applied.

DR. L. BROUQ.

PARIS.

## Selections.

### Treatment of Variola.

DR. MÜLLER, of Franzensbad, says that in the first stage of severe forms of small-pox (invasion with fever) there should be free use of cold, secured by fresh air, light covering, cold applications, and packs. Better results will be secured from these than from antipyretics given internally. They are more rational and less likely to do harm. The second stage (stage of eruption) is the most important one for medical treatment, for here the development of papules and vesicles can be counteracted in such a way as to eliminate the third stage (pustulation) entirely or render it at least harmless. The author has employed for this purpose daily hot baths, and, where full baths could not be given, frequent bathings with warm water. This has been especially beneficial upon the face and about the eyelids, seeming to prevent conjunctivitis at the same time. To produce a drying effect upon the pustules, he has used glycerin in the form of ung. glycerini, which can be applied to the whole body, where lesions are present, after the bath. Upon the scalp he uses a 1-to-300 carbolized oil. In confluent variola and in the suppurating stage he employs (as an external application) cloths soaked in an acetic-acid solution of clay, which are laid over the different regions and bound on. Large pustules can be opened and the base dusted with iodoform. In the period of desiccation, baths are to be given only every second or third day, and starch powder then applied.—*Med.-chir. Rundschau*, June, 1889.

### A Combination of Syphilis and Leprosy.

KAPOSI relates the case of a Russian patient ("Wiener med. Blätter," Dec. 27, 1888) who contracted syphilis in 1884, and four years later a vesicle appeared on the right index finger, followed by an ulcer, which in healing left a depressed scar. Severe sharp pains radiated from this finger up the arm, red spots appeared on this finger and the one next to it, and the sensibility of the skin of the whole hand became impaired. The red spots became enlarged and more elevated until the whole back of the hand became diffusely reddened, and this hand became broader than the opposite one. Here and there on the skin's surface were anæsthetic areas. Neuritis syphilitica was at first diagnosed, but antisymphilitic treatment did no good. Syphilitic affections of the cranial nerves are common, but the spinal nerves are not

often affected. *Lepra tuberosa* is usually readily distinguished from syphilis, but the anæsthetic form often presents features closely resembling syphilitic lesions. The prodromal symptoms may be vague for years until a pemphigus-like bleb forms and is succeeded by an ulcer, and this by a white anæsthetic scar. The red spots and infiltrations may closely simulate a papular syphilide, but in the anæsthetic form there is subsequent muscular atrophy, which makes diagnosis clear. The bacillus is rarely found in the early stages, but it may be detected in the lymphatic glands when not in the skin.

### **Transmission of Tuberculosis by Vaccination.**

THE possible danger from vaccination tuberculosis appears to have been made prominent by the discovery of the virus of tuberculosis, but there is in reality but slight ground for alarm on this score. In animal vaccination only young calves, such as are very seldom the subject of disease, should be chosen, and not only carefully examined beforehand, but, after the lymph has been collected and before it has been given out to be used, they should be killed and examined for any evidence of disease. In using the lymph from a tuberculous calf, the transference of the disease is possible but very improbable. In thirty-eight examinations of vaccination in phthisical patients made by the author, no tubercle bacilli were ever found in the lymph. The cases published since 1883 of cutaneous vaccinal tuberculosis show that inoculation upon the skin either goes no further or does so with difficulty.

### **Tuberculosis of the Skin inoculated by Tattooing.**

M. TOURNIER recently presented before the Society of Medical Sciences of Lyons a patient in whom a verrucose tuberculosis of the skin resulted from the operation of tattooing. The only analogous case is reported by M. Lacas-saque, in the article on "Tatouage" in the "*Dictionnaire encyclopédique*." Claude A., aged twenty-three years, had had gonorrhœa and syphilis. His father and mother suffered from bronchitis; one brother and three sisters had died at an early age. The patient had previously been in the Antiquaille Hospital—five months in 1885 and one month in 1886. During his first sojourn he had hæmoptysis and bronchitis; since this time he had suffered from cough and night-sweats.

In July, 1887, he was tattooed. The operator mixed the China ink with the saliva of the patient. At the end of fifteen days, upon the figure of a ring tattooed upon the dorsal surface of the index finger of the right hand there developed small pin-head-sized vesicles. They were followed by an ulceration, for which a physician had employed during two years various medicaments—tincture of iodine, ointment of sulphur, calomel, tannin, iodoform, etc.

Upon his entrance into the hospital in January, 1889, there was seen at the middle of the metacarpo-phalangeal articulation and upon the dorsal surface of the right hand a verrucose scrofulide presenting the characteristics described by Riehl—a mammillated verrucose surface composed of yellowish crusts, non-imbricated, slightly adherent, beneath a vinous-red surface with cup-shaped depressions, studded with small, very fine papillomatous projections of a whitish color; no ulceration; the derma infiltrated; the periphery of a reddish coloration. This scrofulide was two to two and a half centi-

metres in diameter, but separated into two portions by an islet of skin almost healthy and occupying the seat of the tattooing, which was slightly effaced but not destroyed.

Besides this lesion, there was on the anterior face of the forearm, about its middle, a small abscess of the size of a nut, with the skin reddened and thinned. This small abscess resulted from the breaking down of a pea-sized gumma which had appeared six weeks previously. There still existed a small tumor of the same size and of the same epoch of apparition at the lower third of the internal surface of the arm.

There was no axillary or epitrochlear ganglionic enlargement. Upon auscultation there was found only a slight inspiratory difficulty and dullness at the summit of the left lung.

The gumma of the forearm was opened and gave exit to a grumous pus, which was collected with all antiseptic precautions and examined for bacilli with negative results. A number of guinea-pigs were inoculated with the pus; they died with phenomena of septicæmia. An examination of the products of racleage a month later also gave negative results.

The iodide of potassium was without influence. Under the application of lactic acid, ten per cent., the crusts of the scrofulide fell, leaving a red non-ulcerated surface. The gumma, which had cicatrized after some days of suppuration, again became fluctuating.

On the 9th of February it was again opened, giving exit to a black sanguineous fluid. It did not cicatrize, and in March the surface of the abscess was ulcerated in many points, as if from the breaking down of tubercles. By the confluence of these small ulcerations there resulted an ulcerated surface of two to two and a half centimetres in diameter, with non-adherent borders, quite deep, indolent, and without tendency to reparation.

The patient's general health was relatively good; he still coughs and has night-sweats. Examination of the sputa showed numerous bacilli. The patient had another hæmoptysis on the 15th of April.

This was regarded as a clear case of auto-inoculation of a verrucose tuberculosis of the skin by the saliva, mixed or not with the bronchial secretions. Vidal and Besnier are inclined to think that cutaneous tuberculosis of the hand ordinarily results from auto-inoculation. When patients expectorate, a certain amount of this expectoration remains fixed upon the mustache and the lips, which they are accustomed to wipe away with the back of the hand. These liquids remain in contact with the skin for a more or less extended time, and hence the possibility of inoculation and the explanation of the frequent localization of lesions upon the dorsal surface of the metacarpo-phalangeal articulations of the right hand.—*Lyon médical*, June 23, 1889.

#### **Accidents which may follow the Suppression of a Chronic Eczematous Eruption.**

PARTLY from fear of inducing visceral complications as a result of their too rapid disappearance, partly from an inability to cope with them successfully, medical men used to respect eczematous lesions, and allow them to run on as they would. At present the prevailing opinion is that no harm can accrue to the patient from curing an eczema. Dr. Brocq, while agreeing that

this applies to the large majority of cases, believes that there are circumstances in which the old ideas are correct. Dr. Besnier has remarked that when treating old eczemas of the legs it is necessary to watch the urine, while in treating those of the trunk it is necessary to watch the chest, since inflammatory outbursts might occur in these cases either in the kidneys or the lungs. It is specially important to attend to this when treating emphysematous asthmatics who suffer from chronic eczema. In such the greatest prudence must be exercised; we must wait till the pulmonary organs are in the most perfect state before instituting any efficacious local treatment for the eczema, and suspending this at once as soon as one sees any signs of congestive outbreaks in the lungs. Dr. Brocq relates some valuable cases which fully illustrate these remarks. Those must be studied in the paper itself, which is one of more than ordinary interest and value. It is by no means meant that we are not to treat chronic eczema; it is the mode to adopt in so doing which needs attention. "If we have to deal with a chronic eczema having very little intensity, and causing but little trouble, and the appearance of which on the podex, or the lower limbs, or the articular folds, has coincided with the disappearance of some neuralgia, or migraine, or an attack of asthma, or of bronchitis, etc., so long as the eczema remains limited and does not inflame, nor ooze too much, and does not cause intolerable itching, it would be probably prudent to watch it, to soothe it from time to time, but not to force its disappearance. This is a piece of advice which we would give especially where the disappearance of this eczema has already been accompanied by grave disturbance in connection with the viscera." When such morbid phenomena are developed after the disappearance of a dermatosis, our prognosis should not be too gloomy. In such cases we should act as energetically as possible by means of revulsives; and should under their influence the dermatosis return, and the internal troubles simultaneously vanish, our line of treatment should in the future be cautious. In some of the cases cited by Dr. Brocq a course of treatment at Bourboule appeared to be of much value in bringing about a satisfactory issue. Is it possible that the mere ingestion of considerable or large amounts of water, mildly alkaline, for those unable to undertake such a journey, might prove nearly as efficacious?—*The British Journal of Dermatology*, No. 4, 1889; *Edinburgh Medical Journal*, April, 1889.

### The Treatment of Hypertrichosis.

THE removal of superfluous hair from the face is often a matter of great difficulty, and not infrequently very unsuccessful. The hair will grow again in a provokingly persistent manner, and if too energetic treatment be adopted, a permanent disfigurement often remains to remind the practitioner of his too great diligence. I wish, therefore, to suggest a plan of treatment which I have found very successful in suitable cases for the removal of hypertrichosis, and I will briefly give details of an extreme case:

The first illustration, from a photograph, shows my little patient, three months old, before treatment. The whole right half of her forehead was covered, closely covered, with an overgrowth of long dark hair, some of the hairs being fully an inch long. The adventitious hair grew over the right

eyebrow and eyelid, extended thence across the nose to the margin of the left eyebrow, and upward, a little to the left of the middle line, to the margin of the hairy scalp. On the outer side it grew in a line from the external angle of the right eye to a little above the meatus of the right ear. The child's appearance was, as far as that side of her face was concerned, exactly like that of a Skye terrier. I deferred doing anything till the child was three months old, and in the interval thought over a good many of the plans advised to remove superfluous hair from the skin. I thought them all inapplicable in this case, and finally resolved to risk the trial of the one I now venture to suggest.

When applying sodium ethylate for the removal of *naevi*, I had noticed that when the *naevus* was near the hairy portion of the scalp, if any of it were let to run around its base, the effect was a loss of hair where the ethylate had touched. I tried the effect of the ethylate on several small hairy moles, and, finding the results to have been very satisfactory, I determined to try it in this instance. Accordingly the child was put very fully under the influence of chloroform, the long hair cut short in a vertical line down the forehead for the width of an inch, and sodium ethylate rubbed over the surface very freely and thoroughly, till the skin had an orange appearance. By the time the child had slept off the effects of the chloroform the pain of the application had ceased, so that the child was fairly comfortable. A little cold cream was then applied.

At the end of a fortnight the result of this first attempt was seen, and most satisfactory it was. The hair-follicles over the greater part of where the application had been made seemed destroyed, and a whitish skin remained. Curiously enough, here and there some long hairs remained uninjured. At the end of a month I tried again, but this time I attacked the surface of the forehead from the eyebrow upward, leaving the hairs of the eyebrow alone. The result was the same. Next time I applied the caustic from the margin of the eyebrow to the ear. Then I waited some time to see the result. When the child was a year old the forehead was fairly clear of hair; but the eyebrow and eyelid were still covered with long hair, and that from the eyelid was growing over the eye. I now very carefully applied the ethylate over the eyelid. There was, as might have been anticipated, a good deal of subsequent oedema of the lid, but it all passed off very nicely. The eyebrow now remained, and this I very lightly rubbed over with the ethylate, but this slighter application seemed to have no effect. A second attempt, however, was more successful, for while it did not destroy the hairs entirely, a new growth of weaker, shorter, and much finer hair sprung up. The subsequent progress of the case was slow. It consisted in touching from time to time the hair-follicles that had not been fully destroyed by the previous applications. The child, a healthy girl, is now over six years old, and the second illustration, which is from a recent photograph, shows her present appearance. Her mother writes to me that there is now no disfigurement, the skin hairless, smooth, and nice-looking, but I think the picture speaks for itself.

I wish to add, in conclusion, my conviction of the superiority of sodium ethylate in the treatment of hairy moles over any other method of treatment.

That by electrolysis is often painful, always tedious, and only applicable for limited hypertrichosis, such as that on the lips or chin. In the case of moles where we want not only to remove hairs but also the discoloration of the skin as well, the use of the ethylate has given me better results than the application of any other agent.

Though I have used this method for several years, I have waited till now before bringing it forward, so that I might not without sufficient foundation add another to the list of new methods of treatment, and that I might feel sure that its further trial would not be found disappointing.—Dr. Arthur Jamison, *The Practitioner*, July, 1889.

### Treatment of Prostatitis.

MATTHEW BERKELEY HILL, in his lectures at the Royal College of Surgeons of England, "On Some Affections of the Genito-Urinary Organs," says that the treatment of chronic prostatitis is very tedious. Few remedies are trustworthy. In the first place, dyspepsia must be cured. The most beneficial tonics are the non-astringent forms of iron, to which nux vomica or strychnine may be added, and belladonna if micturition during sleep be a symptom. Ergotine is especially useful when the organ is large, and aching is caused by walking, standing, or railway journeys.

*Local Treatment.*—Cold sitz-bath is a good remedy when the organ is enlarged, soft, and not tender. The bath should at first be taken at 50° F., once or twice daily, and for one or two minutes only, and the duration gradually increased to ten minutes while the temperature is gradually decreased to 35°. The cold douche on the anus and perinæum is also useful. Two to four ounces of cold water as an enema to be retained in the rectum is more generally beneficial than the bath. No faith is put in blistering. When the prostatitis is the result of masturbation or excessive venery, the urine is often more or less bloody. To the touch the organ is little changed. The liquid extract of *salix nigra* in dose of one drachm, three times daily, has often a marked effect in checking involuntary emissions and preventing the irritation, exhaustion, and neuralgia which occur after them. Topical treatment must be omitted after the mucous catarrh and chronic inflammation are quelled. Coitus may be rendered imperfect or impossible by reason of too speedy ejaculation in those who have suffered from congested prostate. In these cases the fluid extract of *damiana* has a powerful effect, but cure is almost impossible if continence is neglected. A condition of helplessness, intense neuralgia of the lower extremities following the shortest walks, pains extending from the sacrum to the occiput even at rest, deteriorated digestion, etc., are complained of. The best remedy in such instances is a quiet life, absence of exertion of any kind, and a long sea voyage. In rare cases chronic parenchymatous prostatitis excites temporary mania which disappears if the physical affection is cured.

### Prostatic Catarrh.

THIS is an affection very common after chronic urethritis or inflammation of the penile portion of the urethra. The symptom of a sense of heat produced by the passage of a sound over the membrano-prostatic portion of the

urethra is one usually present. The changes of the surface as seen through the endoscope are described as granular thickening, enlargement of the papillæ of the surface, and erosions.

Infiltration and condensation changes in the membrane of that part of the urethra do not take place. The prostate becomes marked with slight elevations and depressions of crimson or purplish hue. In the depressions there are little flecks of viscid matter. The shape of the prostatic portion varies considerably. When much congested, the surface rises into a rounded form, and when the congestion ceases the surface becomes nearly flat. Examination with the finger does not detect, as a rule, any change in simple prostatic catarrh. Treatment consists in local applications and in *regime* from which excitement and excessive exercise are excluded. Local treatment is carried out by means of injections of small quantities of astringent solutions and nitrate of silver; occasionally the specifics, cubebs and buchu, sandal-wood, copaiva, etc., are found useful.—*British Medical Journal*, June 29-July 6, 1889.

### Chronic Prostatitis.

FOR a long time the prostate has been a bugbear of internal medicine, and serious and severe are often the affections which have had their beginning in disease of this organ. Posner, of Berlin, called attention to the diagnosis and treatment of these affections in the Wiesbaden Congress for internal medicine held in April last. It is of the utmost importance, says this author, that a correct diagnosis should be made, for such patients are often treated for a lengthy period as neurasthenic individuals until a proper examination reveals the seat of the trouble. This local examination must be made at the first by the rectum, and in this way the form and size of the gland are at once determined. Scarcely ever is a very decided change found in the form of the gland, but as a rule there is upon one side a uniform tense soft swelling. Somewhat more prominent are often the points of tenderness. The most important diagnostic duty is the examination of the secretions. The prostatic fluid in the normal condition is thin and milky, and microscopically there are found in it numerous small bodies of lecithin, besides epithelium, and always, especially after the addition of phosphate of ammonia, are to be seen the large and beautiful sperm crystals as they are called. Round cells are absent in the normal secretion, and it is essentially upon their presence that the diagnosis is based. To this examination is added that of the urethra by means of the sound, and there will be found a more or less decided sensitiveness in the region of the pars prostatica. In this situation the author warns against the forcible use of the sound, and energetically depicts the dangers to which such a procedure may give rise.

The therapy should consist from the first in rest and management, but should be especially directed toward the patients' mind. They must be told of the relative harmlessness of their affection, and the fright that is almost always present should be allayed. Then tonics of all kinds can be used, iron preparations, generous diet, exercise in the open air, baths, and in this way a good result will often be obtained. The author then discussed local therapeutics—first the mild means, consisting in the administration of cathartics. The application of iodide of potash suppositories, at times with the addition of

extract of belladonna, and at the same time the internal use of oil of sandalwood and extract of belladonna, will often be found useful.

Irrigation and caustics are to be restricted to those cases in which an extensive secretion causes one to think of a profuse catarrh of the excreting passages.—*Centralblatt für klin. Med.*, No. 28, 1889.

### The Function of the Prostate.

MR. REGINALD HARRISON gives in the "British Medical Journal" of July 6, 1889, some cases in practice bearing upon the function of the prostate, having already in his Lettsomian lectures of last year laid stress upon the muscular action of the prostate in micturition, including a sphincter action such as we know of in connection with all outlets of the body, and, secondly, the provision of a muscular basis for supporting the bladder and its contents. All deep sections of the prostate radiating from the urethra outward deprive it for a time of its sphincter power, and thus render it incapable of controlling the retention of the urine. Temporary or permanent incontinence may result from the deep incision of lateral lithotomy. One of the objections to the median operation is that this involuntary drainage of the bladder does not take place. The power of the prostate in retaining urine is further evidenced, says the writer, in cases where the urethra has been either extensively or completely ruptured in its membranous portion just in front of the apex of the prostate.

The contracted condition of the prostate, as determined by the finger, has been sufficient to keep back the urine and prevent extravasation for a considerable time. Where extensive operative procedures have been resorted to for the removal of hypertrophied portions of the prostate, including the greater portion of the ring, incontinence of urine is certain to follow. Certain disintegrating diseases of the prostate may be followed by the same incontinence as operation involving the continuity of the prostatic circle—as, for example, the removal of a calculus which has formed within the prostate, and in chronic abscess of the organ, while in such acute abscesses as those associated with gonorrhœa, which are confined to the ducts of the part, permanent weakness rarely results. The author is not at all sure that some cases of incontinence of urine in male children do not depend upon an arrested development in the prostate, and cites a recent case in confirmation, though attributing most cases to reflex causes. The muscular use of the prostate appears to be further illustrated in the passage of a bougie, a sensation of urinating or a desire to do so being experienced by the patient as soon as the instrument enters the prostatic canal. This may be verified either by measurement or with the finger in the bowel.

### Tuberculous Disease of the Prostate.

THIS disease frequently follows gonorrhœa, a catarrhal condition and slight irritation of the bladder being an early symptom, lasting an indefinite time. Frequent seminal emissions, weight in the perinæum, and pain in the sacrum—these call attention to the prostate, and the finger in the rectum finds it irregular, perhaps larger than normal, and tender, especially at the posterior part near the trigone. The disposition of these irregular thickenings is



variable. The ureters and kidneys gradually participate in the septic inflammation, and acute general tuberculosis may terminate the case. The age of those affected is usually between nineteen and forty years. The prostate is often affected before other organs, and, in the absence of tubercle elsewhere, stone in the bladder is thought of. The urine is but moderately turbid in both these conditions at first. In this condition a little shreddy mucus may be washed out with the first portion of urine voided, while in stone in the bladder a drop of blood often comes at the end instead of pus at the beginning of the stream.

*Treatment of Tuberculous Prostatitis.*—In the early stages the catarrh must be cured, and in the later the cavities must be carefully washed out. A good antiseptic solution is two grains to the ounce of the sulphate of quinine, two ounces being injected and left in the bladder after the pus and urine have been well washed out with a boric-acid solution. An emulsion of iodoform is still more antiseptic: Iodoform, two parts; mucilage, four parts; glycerin, two parts; water, twenty parts. If pain is occasioned, a previous injection of cocaine may prevent it. Iodoform emulsion may prevent the necessity of a perineal section to secure constant drainage, but when perineal drainage is resorted to daily, washing is still as needful as when the urine is voided by the urethra. General treatment for tubercle is to be employed at the same time.

#### Extirpation of the Prostate.

DR. STEIN, of Stuttgart, read a paper at the German Surgical Congress upon the removal of the prostate on account of malignant new growths ("Centralb. für Chir.," No. 29, 1889). The fact that malignant new growths of the prostate are so seldom subjected to surgical interference is explained less by the infrequency of these affections than by the dangers of the operation and the difficulties of diagnosis at a stage sufficiently early to warrant it being undertaken in the hope of a successful issue. Until quite recently new growths of a malignant nature were held to be of very rare occurrence in the prostate. Thompson records in his book on prostatic disease a statistical work of Tanchou, in which out of 8,289 deaths from cancer only five were instances of cancer of the prostate. In Winiwarter's statistics of cancer, out of 548 cases we find only one affecting this organ. On the other hand, in the Heidelberg Surgical Clinic during the past eight years there have been six well-marked instances of carcinoma and sarcoma of the prostate. Also in the new work of Kapuche and Engelbach a large number of malignant new growths of this gland are described. Satisfactory results can naturally only be obtained by total extirpation. Out of the six Heidelberg cases, three of which were sarcoma and three carcinoma, operation was carried out in three, the ages of the patients being, respectively, forty-two, forty-seven, and sixty-four years. In the first, thermo-cantery was applied to a carcinoma of the prostate after the bladder had been opened by the high section. Healing took place in four weeks, but the subsequent history is unknown. In the second a total extirpation was done. The operation was begun from above (*sectio alta*), and then a bow-formed cut was made from the anus. The bowel was dissected away and the prostate enucleated from its surroundings. A catheter *à demeure* was introduced and a drainage-tube from the abdomi-

nal to the perineal wound. Various complications arose during the treatment, such as iodoform intoxication, etc., but three months after the operation the patient was discharged, the perineal wound having healed, but the abdominal one not being fully closed. The catheter remained. Patient died nine months later. In the third case, which was one of sarcoma, the whole organ was removed after resection of the coccyx. The patient died on the twelfth day after operation with evidences of a double pleuro-pneumonia. Thus it is seen that the results, including those reported by Billroth, Harrison, and others, are not encouraging; still, the operation should not be given up, as the disease is sooner or later surely fatal, and the pain is often so great that we can not leave the patients in their distressing condition. The most unfavorable prognosis is to be given in sarcoma and in the rapidly growing forms of carcinoma which quickly involve other pelvic organs, and to which Guyon has given the name *cancer prostatico-pelvicus*. A better prognosis is warranted in the slow-growing carcinomata which are confined to the prostate itself. The better will be the chances of success the earlier the operation is undertaken; but the question arises, Are we in a position to make the diagnosis of a malignant new growth in the prostate at an early period? The only disease with which it can well be confounded is hypertrophy of the prostate. The diseases have in the onset much similarity to each other, but there are symptoms which render the differential diagnosis possible. First of all there are the most severe pains radiating down the legs, into the glans penis, and up the back, entirely independent of the act of urination, which is never the case in simple hypertrophy, while during the act itself the pains become insupportable. There are, however, certain cases in which no pains at all are felt during the passage of water; on the other hand, severe pains and tenesmus are experienced on defecation. A very valuable diagnostic aid consists in bimanual palpation practiced during profound narcosis, which informs us of the size of the tumor, its mobility, possible connections with surrounding tissues, and of the enlargement of the glands in the neighborhood. Furthermore, puncture of the tumor through the intestine can give positive evidence of the nature of the growth, as indeed was done in one case reported by Spanton. A small particle of the growth thus secured by puncture showed, under the microscope, that the condition was surely that of sarcoma. As regards operation, that by perineal section is the only possible one. After detaching the gut one obtains good access to the prostate. The seminal vesicles and the lymphatic glands lying in the neighborhood of the prostate, which are usually implicated, are best seen from this procedure, and it also prepares the most favorably conditioned wound for the drainage of urine, which naturally flows continually from the bladder after the operation.

#### Retention of Urine in Hypertrophy of the Prostate.

DR. KÜMMELL, of Hamburg, discussed the operative treatment of retention caused by prostatic hypertrophy at the last Congress of the German Surgical Society. We must all admit, says the author, that the methods of treatment hitherto in vogue can not be said to fully meet the requirements of the case. By puncture of the bladder, introduction of a permanent catheter, the *boutonnière* operation, and other like procedures, we can, to be sure, bridge over the

danger of an acute or chronic retention of urine, but we are not in a position by these means to secure for the patient future power to empty his own bladder in a natural way; and what a sad life it is to go about with a urinary fistula or to be constantly dependent upon a catheter to relieve the bladder! It is deplorable that, with the enormous advances which have been made in surgery, and especially in the surgery of the bladder, prostatic hypertrophy is treated in the manner in which it is. The author is in accord with Dittel's view that we are not authorized, in every instance of retention in elderly men, to open the bladder or to submit the patient to the surely not innocent operation of suprapubic incision for the purpose of seeing if an obstruction is present. A diagnosis can be made without this, and it is surely our duty to make it. He believes that the relative infrequency with which operative interference is resorted to in hypertrophy of the prostate is because the number of cases in which a portion of the prostate impinges upon the bladder cavity and thus impedes the flow of urine is underestimated. With a little practice it is not difficult to assure yourself of the presence of such obstruction, and to make the diagnosis by the combined examination with the catheter and the finger in the rectum, or, if necessary, to make the question sure by the use of the cystoscope according to Nitze's method. In the cases where the author has operated, to the number of six, a diagnostic error has never been made. Advanced kidney affections are regarded as contra-indications to operation, still in one instance the author saw success follow when albumin had been present in the urine, and this indeed disappeared when healing was complete. When the muscular activity of the bladder is affected, and especially if a progressive paralysis of the detrusors be present, the operation will not confer upon the patient an ability to void his urine spontaneously, no matter how successfully it is carried out. It is in such cases that severe septic processes, great disturbance of the general system, fever, etc., necessitate energetic treatment and lead us to perform the operation with a view of prolonging the life which is threatened more than to re-establish the obstructed flow. The six operations mentioned were, with one exception, in severe cases which had for a long time been treated by all usual methods, and in which there were present high evening temperature, severe general symptoms, beginning bronchitis (so much to be dreaded), dry tongue, and, in a word, all those signs so well known to you, and which appeared to the author dangerous to postpone the operation longer. The procedure chosen by Bottini, burning a way through the prostatic portion through the urethra with galvano-cautery, and the median operation, were all put aside in favor of the suprapubic opening of the bladder, which gives a view of the conditions present and gives an opportunity for a more exact operation, more perfect disinfection, and a chance to enlarge the neck of the bladder. He not only extirpates the so-called middle lobe of the prostate, but all the part which projects into the bladder and hinders the flow. In some cases it was a single lobe which was hypertrophied, sometimes a concentric hypertrophy which projected like the neck of the uterus within the lumen of the bladder, or in some instances a horseshoe-shaped mass. A symptom of the presence of a single lobe which the author verified in two instances is the statement of the patients that when they attempt to introduce the catheter it does not enter because a spasm makes the further advance of

the instrument impossible—a contraction of the bladder which for the moment shuts up the orifice with the movable lobe. The operation is carried out so that when the bladder is opened by the high incision and the cavity thoroughly washed out with disinfected sponges and packed with iodoform gauze, etc., the prominent portion of the prostate which stands in the way is grasped with forceps and burned away with the Paquelin knife or the galvano-cautery snare. When necessary, he dilates the neck of the bladder and introduces as thick a Nélaton catheter as possible. In the further treatment it is necessary in the next few days to introduce the largest catheter which will enter. Then the bladder wound is closed by suture. As the patients are all advanced in years, they should be allowed to go about as early as possible to ward against the danger of hypostatic pneumonia.

The continuous catgut suture was used in all cases for closing the bladder, and wherever it was possible the catheter was removed on the tenth day. In the majority of cases the results were favorable, and not only was the danger to the patient's life removed, but the spontaneous voiding of urine was made possible.—*Beilage zum Centralblatt für Chirurgie*, No. 29, 1889.

### Acquired Leprosy as observed in England.

UNDER this caption Jonathan Hutchinson discusses the question of contagion of leprosy in "The British Medical Journal," June 29, 1889, and says the truth is probably nearly this: "No one denies the possibility of contagion in what may be called the abstract or non-practical sense, while all, or very nearly all, doubt whether contagion takes any important share in the spread of the disease." The experience in England is all in the strongest possible sense adverse to the belief in accidental contagion. Not a single sporadic case is ever now seen in England; the cases there are all imported. Feeling sure that the cause is not contagion, little or nothing is left but the all-important question of food, and we are driven to the conclusion that it must depend upon some very special kind of poison of rare occurrence taken in connection with food.

"If we conceive that the bacillus is received into the body in food, and add to our hypothesis that it is by no means commonly present, we see at once how the occasional but very rare infection of those who visit leprosy districts may be brought about."

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## Items.

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**American Dermatological Association.**—The papers thus far announced for the next meeting of the American Dermatological Association, which is to take place in Boston, September 17, 18, and 19, 1889, are as follows: 1. "Clinical Notes on Herpes Zoster," by F. B. Greenough. 2. "Microscopical Studies of Malignant Tumors of the Skin," by C. Heitzmann. 3. "Dermatitis Papillaris," by C. Heitzmann. 4. "Clinical Observations on Injections of Insoluble Mercurial Salts in Syphilis," by H. G. Klotz. 5. "Contribution to Dermatological Bibliography," by G. T. Jackson. 6. "Clinical Notes on Sycosis Capillitii," by J. Zeisler. 7. "On the Occurrence of Prurigo in America," by J. Zeisler.

8. "A Hitherto Undescribed Form of New Growth of the Vulva," by R. W. Taylor. 9. "Two Cases of Eczema Mercuriale," by F. J. Shepherd. 10. "A Case of Urticaria Pigmentosa," by H. W. Stelwagon. 11. "On the Alleged Tolerance of the Iodides in Syphilis," by H. W. Stelwagon. 12. "Observations on a Disputed Point in Infantile Eczema: Some General Suggestions in Dermatological Therapy," by S. Sherwell. 13. "Relapse of Pemphigus Foliaceus after Twelve Years' Quiescence; Case of Impetigo Herpetiformis," by J. Sherwell.

**Vaccine Vesicle on the Tongue.**—Dr. Buckell reports in the "British Medical Journal," June 22, 1889, the occurrence of an accidental inoculation of the tongue due to a kiss bestowed upon the vaccinated arm of an infant by its mother, whose tongue had been somewhat irritated by a fish-bone some time before.

**Enuresis.**—Dr. Richards recommends a combination of bromide of potassium and tincture of belladonna in nocturnal incontinence. He reports two immediate cures in boys of twelve years where the affection had lasted from infancy. Ten grains of the bromide and fifteen or twenty minims of the tincture were given at night.—*Brit. Med. Jour.*, June 22, 1889.

**Elephantiasis Congenita.**—Dr. Waitz presented a two-year-old child at the last Congress of German Surgeons born with greatly enlarged lower extremities which had increased in size since birth. The blood and lymph systems were both affected. There were present conditions of naevus vasculosus, telangiectases, varicosities of different veins, and angiomas. The involvement of the lymphatics was indicated by lymph-filled vesicles from the size of a pin's head to that of millet-seeds, scattered over both extremities, and lymphangiectases and lymphangiomas were undoubtedly present in the greatly increased connective tissue.

**On the Relationship of General Paralysis and Syphilis.**—Regis ("Gazette méd. de Paris," 1888) concludes an article on the foregoing subject as follows: 1. Syphilis has been present in from sixty to seventy per cent. of patients affected with general paralysis. 2. The majority of paralytics have, in addition to past syphilis, an acquired or inherited tendency to the disease, so that the syphilis acts in many cases as the exciting cause only. The syphilitic and non-syphilitic forms are often not to be differentiated, yet in the former class one frequently finds tabetic symptoms, especially paralysis of the muscles of the eye, long before manifest paralysis appears: other complications—as monoplegia, alopecia, an intermittent or remittent course, and a combination of hypochondria with exaltation—are more often met with in the syphilitic form of the disease. Specific treatment is generally without avail, yet there exists a form of pseudo-general paralysis of syphilitic origin which is curable.

**Bromide of Potassium in Ovarian Acne.**—Dr. A. Jamieson, in the "Practitioner" for May, 1889, directs attention to obstinate cases of acne, associated with ovarian irritation and menorrhagia. He finds that the ovarian trouble, the profuse menstruation, and the acne disappear under the administration of bromide of potassium, and he quotes three striking cases in support of this view.—*Glasgow Medical Journal*, June, 1889.

**Erysipelas of the Nasal Cavity.**—Professor Schiffer, of Lüttich, found against this disease, which is caused by the same infective substances as facial erysipelas and with which it is very often complicated, a very effective remedy in tampons of corrosive-sublimate cotton, which are introduced into the nasal cavities. In case of abundant purulent secretion, the nasal cavity is to be washed out with a sublimate solution (strength, 0.5 to 2,000).—*Deutsche med. Wochenschrift*, May, 1889.

**On scraping out Soft Chancres.**—Dr. Oscar V. Peterson ("Vratch," No. 18, 1889, p. 411) says that, in the course of the last eighteen months, he has treated one hundred and twenty cases of soft chancre by means of scraping out after the following rules: Having cleansed the ulcer and surrounding skin with a corrosive sublimate or carbolic solution, he wipes the parts with a piece of cotton-wool soaked in ether, and then treats the chancroid ulcer with a sharp spoon, exactly in the same way as if it were a lupoid or an ordinary atonic one. The procedure over, he dresses the raw surface with iodoform powder and gauze. To make the operation painless, he previously injects under the skin a two-per-cent. solution of hydrochlorate of cocaine. In eight or ten minutes anæsthesia is complete. In simple cases the ulcer cicatrizes, on an average, in 9·9 days. In six out of one hundred and twenty cases healing was complete in three days, and in twenty-five in five days. In anæmic or alcoholic patients, however, cicatrization is not complete before the twenty-second or even the twenty-fifth day.

The author adds that, in 2,953 cases of soft chancre admitted during the period 1881-'87, the average stay in the hospital amounted to 27·5 days. In 1888, however, when the new method was resorted to, the average figure did not surpass 20·7. The percentage of complicated cases varied in the former category between 50·5 and 70·3, in the latter was equal to 62·1.

As to other methods of treating soft chancres, Dr. Peterson eulogizes *painting with pure tincture of iodine*, which is said to give best results in small-sized ulcers of recent origin, but sometimes causes local irritation; and *excision* of the ulcer and adjacent skin, with subsequent application of *sutures*. The wound heals *per primam* in three days.

The method, however, is painful, and in some cases impracticable (for instance, when the ulcer is situated on the glans penis).—*British Journal of Dermatology*, July, 1889.

**Picric Acid** has been employed with excellent results by Calvelli in the treatment of erysipelas, eczema, erythema, and lymphangioitis. He uses a solution of

R Acid. picric.....	1·50 grammes.
Aq. destill.....	250 "

This is applied five to ten times daily, by means of a camel's-hair brush, to the diseased portions of the skin. The favorable action in the case of erysipelas shows itself within twelve to twenty-four hours, especially in the decrease of the swelling and painfulness of the attacked portions.—Dr. Calvelli, *Gazzetta degli ospitali*, 1889.

**Treatment of Pruritis Senilis.**—If pruritis senilis is not complicated with any other dermatosis, Besnier recommends the following treatment: 1. With starch-baths. 2. The itching parts are bathed every evening in water of 40°, to every litre of which is added the following solution:

R Acid. carbol .....	10 grammes.
Acetum aromat.....	500 "
3. Then the bathed parts are powdered with the following:	
R Amylum.....	90 grammes.
Bismut. salicyl.....	20 "
Or,	
R Acid. salic. subt. pulveris.....	20 grammes.
Amyli.....	180 "

Through light rubbing this powder is made adherent.—Besnier, *Bull. méd.*, No. 34.







# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### A COMBINATION OF PSORIASIS AND PURPURA RHEUMATICA.

By J. A. FORDYCE, M. D.

A PATIENT has recently been under my observation at the New York Polyclinic affected at the same time with two independent diseases of the skin. On parts of the cutaneous surface each disease has preserved its own characteristics; on other parts they are combined, presenting, however, the distinctive marks of each. Such union of these diseases is certainly rare, I being unable in dermatological literature to find a similar observation. Among my notes taken during a visit to the Baretta Museum of the St. Louis Hospital, in Paris, I find a reference to a "moulage" representing psoriasis and purpura on the same individual; but whether the lesions existed independently or combined, as in my case, I do not now recollect.

The simultaneous occurrence of these two diseases is interesting on account of its rarity, but more so as a like cause has been invoked to account for their production.

The history of my case is as follows:

James McD., aged forty-one years, native of England. His father and mother are living, at the ages of seventy-five years; neither are nor have been affected with psoriasis or rheumatism. He has two sisters who, he says, suffer with a scaly skin eruption of the same character as the one he presents; aside from their skin disease they are in good health.

He is addicted to the periodic indulgence in alcoholic drinks, but has enjoyed good general health independent of the troubles about to be mentioned. As long as he can recollect he has had a scaly eruption about the extensor surfaces of the knees and elbows, which would spread from there to the trunk, scalp, and over the extremities. This eruption would at times disappear, then reappear. It has pursued this course through years. He says the scalp

was first involved ten years ago, long after the eruption appeared on the extremities and trunk. During the past three years he has suffered at frequent intervals from pains and swelling in the knees and feet; from his account, it would appear that the joints were not directly involved, but that the swelling and pains were in the vicinity of the articulations. He recalls sudden tumefactions from the size of a pigeon's egg to the size of a hen's egg about the knee and ankle and at intermediate spots between these joints. These swellings would be preceded and attended with pain; they would usually last for several days before disappearing, sometimes gradually, more often, however, suddenly. He can not recall whether in disappearing any change in their color took place.

Four months ago he began to suffer with pains of a burning character, and with "pins-and-needles" sensations in the legs below the knees. On the spots where these sensations were felt a purpuric eruption appeared, the appearance of the eruption coinciding with the disappearance of the pains.

The eruption consisted of purple spots, not raised above the surface, distinctly circumscribed, and not disappearing on pressure. About the knee and ankle joints, and on the dorsum and inner surface of the foot, circumscribed painful swellings were noticed. Motion of the knee and ankle joints was attended with decided pain. On several occasions during the past few months he has passed blood by the rectum, but has had no hæmorrhage from any other mucous surface.

The skin eruption and painful swellings have disappeared and reappeared several times since their onset, an over-indulgence in alcoholic stimulants having on several occasions preceded an outbreak. Symptoms of constitutional disturbance have been present, although he does not think he has had fever.

An examination shows characteristic spots of psoriasis on elbows, knees, trunk, scalp, face, and thighs. Below the knees a disseminated scaly eruption is present having a violaceous base, and showing beneath the scales a petechial eruption capped by a small blood crust, as if capillary hæmorrhages had been caused by the detachment of the scales. (See colored plate, Fig. 2.) In the upper half of the leg the violaceous color disappears almost completely on pressure; as the neighborhood of the ankle is approached, however, the color is uninfluenced by pressure. Spots of purpura having an irregular boundary are present on the dorsum and the inner surface of the foot.

The knee and ankle joints are painful, and on the inner surface of the right knee and dorsal surface of the feet the painful subcutaneous swellings before mentioned are present; on the dorsum of the left hand, over the metacarpal bone of the thumb, an exquisitely sensitive swelling is also present. An examination made one week later shows that the purpuric spots are transitory in duration; spots which were purpuric at the former examination show only traces of their past existence, and showing the changes in color produced during the absorption of a blood extravasation.

The subsidence of the cedematous swellings on the lower extremities leaves a purpuric staining of the skin; this is not the case, however, on the hands.

An examination of the heart reveals no organic lesion, nor was the urine found to contain albumin.

In considering the foregoing case we see that, although psoriasis is present in two other members of the patient's family, a rheumatic history is distinctly denied; furthermore, that the psoriasis existed for years before any manifestation of the articular pains or eruption.

The advent of the eruption and pains in the joints after alcoholic excess would indicate a relationship of cause and effect, inasmuch as such a connection has been observed. The presence of a purpuric eruption having been preceded by pains and swellings of the joints is sufficient to constitute the disease described by Schönlein as *peliosis rheumatica*. Whether this form of purpura is a distinct disease dependent on the rheumatic poison—a form of exudative erythema—or only a minor degree of *morbus maculosus*, is a question not yet determined.

The occurrence of transition cases between the so-called *peliosis rheumatica* and *purpura hæmorrhagica* would seem to disprove the validity of creating an independent type of disease; indeed, my own case presented, in the hæmorrhages from the intestinal canal, a symptom of *purpura hæmorrhagica*, thus supporting the opinion advanced by Immermann\* that *purpura rheumatica* is only a less severe form of *morbus maculosus*. The coexistence of *purpura simplex*, *purpura rheumatica*, and *purpura hæmorrhagica* renders this theory plausible.

F. P. Kinnieutt,† after a *résumé* of the views of German, French, and English dermatologists, with an analysis of a number of cases of *purpura rheumatica*, together with the observation of a case of his own, concludes that the affection presents a group of symptoms sufficient to permit of a differentiation of the affection from both *purpura* and *erythema nodosum*, and that it should be accorded the position of a well-defined and independent affection.

This view of the matter is not supported by Kaposi,‡ who is disposed to classify *purpura rheumatica* among the exudative erythemata, rather than with *purpura*. He supports his opinion by remarking that *purpura rheumatica* is often found associated with the other manifestations of exudative erythema—as *herpes iris*, *urticaria papulatum*, and *erythema nodosum*.

Crocker,\* among the recent English dermatological writers, accepts this view, and also remarks that *purpura rheumatica* differs in no manner from *erythema multiforme*, except that hæmorrhage into the extravasation is constant in the latter and exceptional in the former.

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\* Immermann, art. "Morbus Maculosus," Ziemssen's "Cyclopædia of the Practice of Medicine," Am. translation, vol. xvii.

† "Peliosis Rheumatica," "Archives of Dermatology," vol. i, p. 193.

‡ "Pathologie und Therapie der Hautkrankheiten," dritte Auflage, Wien, 1887.

\* "Diseases of the Skin," London, 1888.

Osler's \* cases, which began as purpura associated with articular pains and swelling of the joints, followed later by gastro-intestinal irritation, hæmorrhages from the intestinal tract, albuminuria, and, in some cases, ending fatally, would certainly show the close relationship between the lighter and more serious forms of purpura. He remarks that the interchangeability of these cases of purpura with urticaria and with angio-neurotic œdema favors the suggestion that this group of affections may depend upon some poison—an alkaloid, possibly—the result of faulty chylipoietic metabolism, which in one may excite a form of urticaria, in another a peliosis rheumatica, and in a third a fatal form of purpura.

The close relationship of purpura rheumatica with the rheumatic poison would seem in some cases to be quite clear, in view of the fact that pathological changes in the affected joints have been found at the post-mortem examination, as in a case described by Lenthold,† and that aortic insufficiency has also been seen to develop in the cases described by Schwartz, in Kaposi's clinic.

All the forms of exudative erythema occasionally occur during the course of an acute articular rheumatism, either as a reflex angio-neurotic affection or as a direct result of the rheumatic poison.

The vaso-motor theory of Fabre‡ makes all forms of purpura a disturbance of innervation, so that any cause which is sufficient to disturb the equilibrium of the vaso-motor center—be it rheumatism, ptomaines, or other organic or inorganic poison—could induce the condition. Whether erythema nodosum has distinctive features enough to entitle it to be recognized as an independent affection is doubtful; at all events, the two affections are closely allied, as they frequently occur combined, affect by preference the same regions of the body, occur at the same seasons of the year, and both forms of disease complicate the rheumatic state.

Lewin has found other forms of erythema along with erythema nodosum in twenty-five out of fifty-five cases. Poltebnoff § considers erythema nodosum as a modification only of erythema exudativum, distinguishable by a deeper seat and greater degree of intensity.

Although there are good reasons in some cases of purpura for establishing a close relationship between it and rheumatism, fewer and less valid ones can be invoked to connect psoriasis with the rheumatic condition. Since my attention has been called to a possible relationship between rheumatism and psoriasis, I have interrogated all the patients who

\* "On a Rare Form of Purpura associated with Articular, Gastro-intestinal, and Renal Symptoms," "New York Medical Journal," December 22, 1888.

† "Berliner klin. Wochenschrift," 1865, No. 50.

‡ Fabre, "Les relations pathogéniques des troubles nerveux," Paris, 1880.

§ "Zur Lehre von den Erythemen," "Dermatologische Studien," fünftes Heft, Hamburg, 1887.

have come under my care with the latter disease, but in a few cases only have I succeeded in obtaining a personal or family history of rheumatism.

It is in France especially where the coexistence of psoriasis and rheumatic affections of the joints has been observed. Bourdillon,\* in a recent work on the relationship of these affections, has collected and analyzed thirty-six cases in which the two diseases occurred in the same individual; the greater number of these cases were observed in the wards of the St. Louis Hospital of Paris.

The joint affections observed were of all grades of severity from simple articular pains to the most severe forms of arthritis deformans. In the greater number of these cases, however, the involvement of the joints occurred long after the appearance of the cutaneous affection, and in many of them not until the psoriasis had been transformed into an exfoliative dermatitis. Alibert† mentions briefly the occurrence of joint affections during the existence of psoriasis.

Rayer‡ cites the case of a patient afflicted with a psoriasis of eighteen years' duration, who entered a hospital suffering at the same time with psoriasis and rheumatism. Gibert,§ in the chapter devoted to squamous affections, speaking of a female patient under his charge, says :

"This woman presents the most serious case of such affections that I have ever seen : the body, dried up and almost mummified, with rigidity and contractures of the joints, presents everywhere a surface like parchement. She left the hospital after a residence of several months, then returned later, and died in the last degree of marasmus and emaciation."

Cazenave|| relates the case of a very distinguished scholar who had been afflicted during a number of years with a generalized psoriasis, in whom periodically acute exacerbations with swelling, redness, and the more abundant production of scales took place, attended with malaise and some febrile movement. During the first few days of his attack it was impossible for him to move ; at the expiration of several weeks he recovered little by little his former state. Besides, adds Cazenave, the articulations were swollen, the joints deformed, and the vertebral column curved.

A second case is reported by Cazenave in which not only the skin, but the joints also were affected by psoriasis, during which the last phalangeal joints became affected with a painful and inflammatory swelling, followed by an increase in their volume. Under the influence of Fowler's solution the skin disease became ameliorated, but the joints remained painful and swollen.

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\* "Psoriasis et Arthropathies," Paris, 1888.

† "Traité des maladies de la peau," edition 1822.

‡ Tome ii, 1835.

§ Gibert, 1839, "Traité des mal. speciales de la peau."

|| Cazenave, 1847, "Abrégé pratique des mal. de peau."

Cazenave reports these cases without commenting on their relationship, whether it was that of cause and effect or mere accidental coincidence.

Devergie,\* having observed the occurrence of swelling in the joints of the fingers and toes during the existence of a generalized psoriasis, asks himself the question if this condition of the small joints which resembles gout, the osseous tophi alone excepted, depends exclusively upon psoriasis, or if it only shows itself under the influence of this malady when the subject had been formerly the subject of rheumatic manifestations.

Bazin † was disposed to assign all cases of psoriasis to the effect of diatheses, and divided his cases into two classes—*psoriasis arthritique* and *psoriasis herpetique*.

In one of the cases quoted by Bazin to uphold his theory, the patient suffered with articular and muscular pains before the appearance of the skin affection.

The former existence or presence of articular pain during an attack of psoriasis was sufficient to constitute, in his mind, a psoriasis arthritique. Pioget,‡ Adams,§ Duron,|| Germain,^ and Duckworth◇ have observed and commented on the association of these maladies.‡

Besnier has stated that among one hundred patients affected with psoriasis, five are found who present some form of joint trouble, but only one who has general arthritis deformans. This percentage appears too large for our own country, where the association of the two maladies has scarcely been noticed. It may be, however, that their coexistence has been overlooked.

The form of joint affection which has most frequently been observed to accompany psoriasis is an arthritis resulting in ankylosis and deformities whose rheumatic nature is very questionable, and whose ætiology is not well understood; it is certainly more closely allied to the arthropathies

\* Devergie, "Traité des maladies de la peau," 1854.

† "Leçons théoriques et cliniques sur les affections cutanées de nature arthritique et dartreuse," 1868.

‡ Pioget, "Psoriasis arthritique," Société anatomique, séance du 31 mars 1878.

§ Adams, "Observation concerning the Association of Psoriasis and Osteo-arthritis," "Medical Press and Circular," London, 1881.

|| Duron, "Quelques considérations sur les rapports du psoriasis et du rhumatisme, et en particulier, du rhumatisme fibreux," "Thèse de doctorat," Paris, 1886.

^ Germain, "Psoriasis associé au rhumatisme," Société des sciences médicales de Lyon, 10 nov. 1886.

◇ Sir Dyce Duckworth, "Observation concerning Psoriasis associated with Rheumatism and transformed into Pityriasis Rubra," London "Lancet," April 9, 1887.

‡ I have taken the foregoing historical facts from the work of Bourdillon on "Psoriasis and Arthropathies," without consulting the original references, except in a few instances. They show that, with two exceptions, the observations have been made by French writers.

that develop during tabes than with the joint troubles of rheumatic origin.

Cases in which the arthropathies preceded the psoriasis are rare, the greater number developing joint troubles after suffering for years with extensive or universal psoriasis. We might conceive that an extensive involvement of the cutaneous surface could so far impair the bodily nutrition as to indirectly produce this condition. This theory certainly seems more plausible than to ascribe both affections to a common cause—a neurotic disturbance.

Psoriasis, as ordinarily met with, does not impress one as dependent upon a constitutional derangement or neurotic influence; on the contrary, we have every reason to look on the disease as one of mycotic origin. The spread of the disease from a localized spot, its rapid dissemination, the central involution and peripheral evolution of the patches, its assumption of circinate and gyrate forms, its superficial seat in the cutaneous structure, the rapid suppression of the disease by antiparasitic remedies—all speak strongly in favor of a mycotic origin. The similarity of psoriasis, in its clinical history, to the other vegetable parasitic affections of the skin led Lang\* to the belief that a fungus was the cause of the disease, and later he succeeded in finding a fungus in the rete layer, immediately above the papillæ, where the disease is supposed to begin.

The presence of Lang's fungus in the lesions of psoriasis has not been generally confirmed, neither has its relationship to the disease been proved by cultivation and inoculation experiments, the non-contagious character of the affection rendering investigations of this character difficult or impossible. It is now announced that Dr. Destout, of Lyons, has unquestionably proved the parasitic origin of the disease, and that an inoculation made by him on May 9th caused the appearance of the eruption on the 25th of the same month; should his inoculation experiments be confirmed by subsequent investigation, psoriasis will have to be removed from the skin affections dependent upon a constitutional condition and assigned to a place among the parasitic diseases.

The association of the two diseases which forms the subject of this paper, though interesting by reason of its rarity, can scarcely be looked upon as other than an accidental one, in view of the fact that we have not sufficiently valid reasons for ascribing them to a common cause—rheumatism.

66 PARK AVENUE.

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\* "Versuch einer Beurtheilung der Schuppenflechte nach ihren klinischen Charakteren," "Vierteljahresschrift f. Dermat. u. Syph.," 1878, p. 433.

## THE TREATMENT OF INFLAMMATORY DISEASES OF THE SKIN.\*

By OSCAR LASSAR, M. D.,  
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NOWHERE in the whole domain of medical science do opinions differ more than in the treatment of diseases of the skin. Nor is this strange when we consider the variability of the cases themselves, the marked differences of sensibility, and the different conditions which surround them. This explains why such a diversity of opinion obtains. Most dermatologists follow a mere symptomatical line of therapy, and the hand-books vainly endeavor to teach that the indications are sufficiently clear to enable one to determine the special cause of treatment to pursue. From this it is quite natural that personal experience should stand paramount. We see the force of this when we consider that the experience and teaching of an authority like Hebra even to-day give direction to the treatment of diseases of the skin employed by most medical men. When we consider, too, that long before that remarkable man closed his eyes, and even during the last decennium of his life, general pathology had become essentially changed, we feel how necessary it is to accommodate our therapeutical standard to the advanced ideas of the present.

During the three years that I enjoyed—as assistant in the pathological institution of Breslau—the happy influence of my ever-remembered master, Cohnheim, I was imbued with a strong predilection for everything connected with the subject of inflammation. I have since followed this line of work in my observations of diseases of the skin. Struck by the resemblance of pathological anatomy to the vivid forms of derangements of the skin, I endeavored to improve by personal experience the theoretical teaching I had obtained. Through the kind support of my colleagues I have been favored with an ample field of observation during the past ten years, and I have been able to study in variety the treatment of inflammatory diseases of the skin.

It matters not what name we give to a certain morbid state if we but agree upon the meaning of that name. Now, there exists a difference as to the meaning of the term *eczema*; almost every one gives a different explanation. We do not mean simply an *inflammation* of the skin, for eczema covers such a wide range of conditions that it seems almost impossible to include them under one clinical unity. Conditions of most varied nature and combination produce such a variability of symptoms as to render every case a study in itself.

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\* Read before the Section in Dermatology and Syphilography at the American Medical Association, June 27, 1889.



The truest form of inflammation of the skin will always be that produced by a single artificial cause. Chemical and caloric lesions of the tissues, be they traumatic or experimental, furnish the most characteristic examples, and have always served as the basis of aetiological study. But in reality the course of a disease soon becomes independent if it is not so from the onset. Every inflammation of the skin pursues its own course. When the first exciting cause of the inflammation has altered the conditions of the vessels, the state of coagulation of the tissues and their capacity of resistance, the effect does not disappear with the cause, since new irritations take the place of the old. Thus only may be explained how strong lyes act upon washer-women, turpentine upon painters, polishing-solutions upon joiners, chromic acid upon laborers, lime-lye upon bricklayers, and carbolic acid and solution of sublimate upon surgeons. The effect of these applications continues a long while beyond the time of the original contact. The skin, once irritated, will now be affected by substances which it before resisted. The slightest contact (as friction of the clothes), warmth, and cold become noxious to the well-being of the skin. These artificial states are the only ones which are congruent with the old name of *eczema*. Professional *eczemas* are so common in Germany that abundant opportunities are afforded for studying this kind of pathological alteration. There are various types of disease, and these are further complicated by a consecutive irritation of the skin. This latter often veils the real connection, and, by its more violent and evident symptoms, may mislead the observer. We shall do well, therefore, to separate as completely as possible those added irritations from the original and essential disease. In the first line there are herpes, intertrigo, prurigo, scabies inveterata, erythrasma, and itching forms of common psoriasis, which so often become complicated by accidental irritations. Often you will remark the development of an *eczema herpeticum* which follows the symptoms of a merely traumatic, chemical, or caloric inflammation of the superficial layers. Irregular circles begin to form either in the midst or in the neighborhood of the inflamed region. They are dry and of a dark, dirty redness, and resembling a slight psoriasis or an inveterate case of herpes squamosus. The patches become thicker and larger day by day. They spread slowly but constantly, and sometimes run together into extended plains of irregular dimensions and limits, but nearly always to be recognized as made up of single circles of the disease. The previous inflammation may have existed a long time, but these herpetiform eruptions retain their character for months and even years. Some are disappearing while others are appearing. The process is like a vegetable growth which finds the means of spreading in itself. This very obstinate and troublesome addition to the original eruption may be avoided if we cure the first outbreak of the inflammation. But this is not often possible, because most people

neglect their first eczema, and few surgeons act with sufficient energy against this apparently mild affection.

Another form of cutaneous eruption which may lead to eczema is the *pityriasis rosea* (Gibert), or herpes squamosus (Hebra). This is believed to be more rare than it really is, most probably because it is frequently masked by an additional eczema. It may be well to mention in this place that a surprisingly large number of these cases occur in young ladies who wear Jersey waists, which are bought in the shops and worn without being washed or disinfected.

Many apparently idiopathic eczemas are caused by *intertrigo*. Sweat and the altered secretions of the cutaneous glands decomposed by stagnation soften the epidermis and open its doors to the invasion of many physical and fermentative elements of irritation. From wounds we have the skin infected. Dermatitis exfoliativa and bullosa, pemphigus, lymphangitis, and moist, dry, or purulent tetter, have in this way originated from intertrigo, especially in children.

One of the most misleading kinds of secondary eczema is from prurigo—not so much the real prurigo agria, whose symptoms are so very well marked that an error can scarcely arise—but there is another kind, which ought to be named prurigo regionalis; for in real prurigo we are not able to recognize anything but the consecutive symptoms of an obstinate itching; so we find in prurigo regionalis merely the same disorder localized in some parts of the body, and without any predilection of sex, age, occupation, or social position. It begins in the apparently healthy skin, selecting the nape of the neck or the face. The spots become only visible by constant scratching and rubbing, and are of a motley yellow or bluish color. In time you see nothing but a limited eczema—an eczema due to scratching.

I can not venture to go further into this attractive theme, but I have thought it necessary to allude to the foregoing points of view. They will lead us to distinguish between cause and effect, and also enable us to understand the indications for treatment.

The first care should always be to soothe any state of irritation of the skin, and clinical experience has taught that the preliminary steps should be to clean the surface as thoroughly as possible. This can be done only by baths. It is well known that a large majority of practitioners fear to touch inflamed skin with water, and consequently forbid washing or bathing. It is a most remarkable evidence of the dominant influence of the teachings of Hebra that, even at the present day, this opinion of his has lost nothing in value in the eyes of the medical world. But it can be no longer upheld, since experience has shown that even the most violently inflamed skin bears nothing better than a tepid bath. In surgery nobody would venture to leave the dirty and decomposable products of inflammation within the field of absorption. The principal rule of every hygienic

proceeding consists in absolute cleanliness. *A priori* there can not be imagined any reason why the skin should be an exception to this rule, and in fact the *dreaded malignant influence of water upon inflamed skins does not exist in reality*. Perhaps an excess of its application might involve the same disadvantages as the excess of any other treatment. But it must be said that water in the form of baths does not produce the slightest harm to the inflamed skin.

The method of treating inflammatory diseases of the skin in my clinic has been for several years as follows :

The patient is put into a bath of 26° to 28° C. (to which may be added a few pounds of bran), and gently soaped with green or toilet soap. Generally after this the tar treatment is begun, except in very acute or delicate cases, or when no pruritus exists. The tar formula is as follows :

℞ Ol. fagi pinguis,  
 Ol. rusci.....āā 40·0  
 Ol. olivar..... 20·0

M. Sig.: Tar.

In children, women, and very sensitive persons, or in delicate regions—like the inner aspect of the joints and the scrotum—it is better to dilute the tar with oil. The tar is only to be applied during the bath, and should be washed off before leaving the water. At the end of the bath the temperature of the water is to be cooled a few degrees, and at last the patient is to use a tepid or cold shower bath. Immediately after the bath the whole skin is to be covered with some oily or fatty preparation, thus protecting it from the air as well as possible.

The leading principles of the treatment are :

1. The removal of all pathological adhesions.
2. The short application of different tarry preparations.
3. A permanent application of emollient and indifferent preparations.

Chief among the latter is a two-per-cent. salicylated paste of—

℞ Acid. salicyl..... 2·0  
 Vasin flavi..... 50·0  
 Zinc. oxyd.,  
 Amyli.....āā 24·0

Misce leniter terendo f. pasta.

The advantages of this paste are that it is generally well borne. Be it a child of a few weeks or an old person, the influence is a benignant one. It produces a slight, soft sealing, and, besides, a constant drying, because it acts like a filter. All lymphatic exudations pass this porous layer, and are drawn out into the bandage, instead of forming a crust upon the wounded skin itself. This is an important advantage for the completion of regeneration, because the neighboring epidermis is not obstructed by masses of adherent crusts. The bandages are to be made of thin layers of cotton,

and some few turns of muslin where applicable. This gives the advantage of preventing the germs in the atmosphere, as well as the dirty nails of the patient, from disturbing the process of healing. But the different conditions in each case make it necessary to employ more than one method. In all states where the corium is exposed some difficulty may be experienced in cleaning the wound properly from the dried paste, and in these the application of oil is to be used. In dermatitis bullosa, erysipelas, scalds, and pemphigus, the antiseptical oil-bandage is to be highly recommended. Of course, carbolic acid should be omitted in children, or where large tracts are involved. But the salicylic acid is quite harmless, as well as thymol, and these preparations are easily dissolved in the oleum olivarum, or the cheaper oleum raparum. In cases of burning, the oil must be iced, and the compresses and bandages be changed as often as seems agreeable to the patient. This method prevents the patient from touching and scratching the affected surface, and the protective character of the whole treatment should never be lost sight of. Considering that numerous specimens of micro-organisms exist under the human nails, it is not astonishing that the mere protection of the inflamed tissues is of the greatest benefit.

Besides the paste, I might mention the two-per-cent. salicylated vaseline which is especially applicable to the hairy parts of the body. It must not be forgotten that it is necessary to apply it freely in order to protect the skin. In the case of a baby with the usual unfavorable appearances of a moist or a purulent dermatitis, you can change the whole appearance in a few days if you bathe the baby as you would do in health. Touch all open spots, all bleeding and lymphorrhagical stomata with a three-per-cent. solution of *nitras argenti*, cover the whole body with the salicylated paste, the head and joints with the two-per-cent. salicylated vaseline, and fix the bandages so thoroughly that no struggling can remove them. The fretful, unhappy little creature will become a clean and laughing being within a shorter space of time than under any other mode of procedure hitherto known.

There are many ways of successfully treating eczema, and it is possible that among this learned society far better ones than the above-mentioned are practiced. Yet it is well for us all to have at our command every possible resource which may serve in obstinate cases of inflammatory diseases of the skin. Further, it may be well to allude to some other methods of correcting the symptoms of dermatitis. In many cases you will obtain benefit from the application of French chalk (talcum). The skin is to be cleansed by bathing, and immediately afterward covered with the thickest imaginable layers of this innocent powder. The patient should be kept in bed and the nurse should cover him with clouds of the chalk every half-hour.

I can not close these few remarks without mentioning an ointment which does a great deal of good in all pustular affections of the hairy parts of the head and beard. It came into my hands through a shepherd who wished to enlarge his professional knowledge by visiting my clinic. In order to introduce himself he showed a salve, which he said had a miraculous effect upon skin diseases. The preparation seemed of some use, and I procured a sufficient quantity to test its virtues. The chemical analysis brought out the following simple formula :

R Hydrargyri sulphurati rubri .....	1·0
Sulphuris sublimati.....	24·0
Adipis.....	75·0
Ol. bergamottæ.....	gtt. aliquot

This same prescription had already been used by Dr. Bielt, of the Hôpital St. Louis, some fifty years ago, and has thus been recalled to the domain of dermatology. It is very useful indeed and perfectly harmless. Especially its effect is to be remarked in all impetiginous affections of the hairy regions.

The beneficial effect of all these remedies can be favorably supported by the cautious application of chrysarobin and pyrogallol. These are only dangerous when we leave them long upon the surface, but they prove very effective and harmless when taken away after a short application. The most obstinate forms of pruriginous eczema with an inflamed base are best treated, if in a systematical way, by these antiparasitical remedies applied for a short time, and afterward covered with the previously mentioned paste, or the benzoated zinc ointment. It has not been my object to give an exhaustive description of the whole therapy at our command, but simply to communicate a few practical hints, hoping that some of them may prove of use to my most honorable transatlantic colleagues.

19 KARL STRASSE.

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## THE HYGIENE OF THE SKIN IN HEALTH AND DISEASE.

By JOHN V. SHOEMAKER, A. M., M. D.,  
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**A**LTHOUGH the skin, like every other human tissue, possesses a definite chemical and morphological constitution, yet certain minute structural and vital differences exist between the cutaneous envelopes of different individuals. Just as, in the same person, the skin is thicker in certain regions than in others, so a certain difference in comparative thickness is observed between the skins of different persons. But this is, perhaps, the least difference of texture to which it is liable. A

much more important distinction relates to the sensibility of its nervous elements and the activity of its circulation. These variations, especially under the influence of favorable circumstances, are perpetuated or, it may be, heightened in transmission from parent to offspring. One of the functions of the integument, by virtue of a special modification of the terminations of sensory nerves distributed to its surface, is to put us into relation with the external world through the sense of touch. It is reasonable to suppose that the acuteness of tactile sensibility exhibits a natural variation in the same manner as the senses of sight and hearing differ in different persons. The sense of touch, like the other special senses, bears a relation, likewise, to the general development of the nervous system, both central and peripheral. The highest intellectual activity, the most exquisite sensibility of ear, of eye, of touch, and of muscular adaptation, must combine to render possible the works of a Mozart, Beethoven, or Mendelssohn, of a Raphael, Titian, or Michael Angelo. How highly the sense of touch may be cultivated we see in the blind, who receive a partial compensation for the loss of sight by the increased acuteness of hearing and touch. A comparatively thin epithelial covering permits us to observe, "as in a glass darkly," varying constitutional conditions—the bloom of health, the pallor of the consumptive, the ashen hue of the confirmed dyspeptic, the sallow tinge of the unfortunate victim of malignant disease, etc. The vaso-motor nerves, which govern the caliber and capacity of the vessels of the skin, respond quickly, in some constitutions, to stimuli, either external or internal, while in those of more stolid disposition they are far less easily excited. On the face of the gently nurtured girl the experienced eye may detect the trace of every powerful emotion, while one may look in vain upon the cheek of the youthful inmate of a house of refuge for the blush of shame.

The capillaries of the skin are brought into such close proximity to the atmosphere that an interchange of gases takes place; carbonic acid is given off and oxygen absorbed. The quantity of carbonic acid exhaled has been estimated by Scharling at one fiftieth and by Regnault at one one hundredth that expired by the lungs, the latter calculation being probably nearer the truth. The perspiratory tubules begin in a convolution and pursue a spiral course. They thus resemble the tubules of the kidney, and perform an analogous function. Sir Erasmus Wilson calculated that the number of square inches of surface in a man of ordinary height and weight is 2,500; the number of inches of perspiratory tube opening upon this surface, 1,750,000—that is, 145,833 feet, or 48,600 yards, or nearly twenty-eight miles. This enormous extent allows an active elimination from the blood. The perspiration holds in solution about one per cent., on an average, of solid material, consisting of inorganic and organic compounds, the most important of the latter being urea. Therefore the lungs, the kidneys, and the skin are, to a certain extent, complementary to each other. Moreover,

the perspiration is not only an excretory fluid, but it also serves a valuable purpose in regulating, or assisting to regulate, the bodily temperature. This cutaneous respiration and transpiration, which are incessantly carried on with more or less activity, must play an important part in the depuration of the blood. In a state of health we are, I fancy, too apt to overlook this truth, but its value becomes apparent in certain pathological states, as, for instance, uræmia, where we invoke the assistance of the skin as an emunctory in relief of the disabled kidneys; in lead poisoning, jaundice, and syphilis. If the circulating fluid be laden with toxic agents, be they engendered without or within the organism, the skin performs a share of the work of elimination. In the execution of this work it is very apt to become injured—strained, so to speak—and this injury is expressed in the form of some inflammatory disease of the skin. Again, if the skin be functionally impaired, the whole work of excretion is thrown upon the internal organs; substances unfit for nutrition tend to accumulate, with harmful and often fatal consequences. The internal organism and the skin which envelops it are continually acting and reacting upon each other. The sebaceous material also, probably, subserves to a less degree the purpose of selecting waste products from the blood, besides its more obvious use as a natural unguent. If the function of the sebaceous glands be improperly performed, the result is either a suppression, leaving the skin dry and harsh, liable to excoriations, scaly formations, etc., or the quality of the sebum is entirely altered, so that the skin is covered with a greasy liquid, or with dingy scales. The morbid process may be so severe as to lead to loss of the hair. The hair also assumes a faded hue and loses its curl when it suffers from a deficient or improper supply of nutriment.

The health of the skin is due, in the first place, to an adequate supply of healthy blood; in the second, to the proper performance of its eliminative functions. The fulfillment of the first condition involves a healthy execution of the varied and complicated processes by which the blood is generated and maintained in purity. The second consideration involves attention to many habits of life, such as clothing, cleanliness, and exercise. No fault of general nutrition, no careless bodily habit—I might almost say, no evil moral trait—can be wholly without effect upon the health of the skin. Accordingly, a complete treatise upon the care of this tissue demands a study of physiology and of the habits of civilized life.

The beauty of the skin depends upon the activity of its circulation, the shade of the pigment deposited in its rete mucosum, the depth of its epithelial covering, and, of course, its cleanliness. The pigmentation varies in shade in accordance with the color of the eyes and hair, a fair skin, as a rule, accompanying light hair and blue, hazel, or gray eyes, while a dark skin is found in dark-eyed and dark-haired people. Climate has something to do with the complexion, since we find that Northern

peoples are generally blonde and Southern brunette; yet among the natives of Europe, in whom considerable mixture of blood has occurred, we find numerous exceptions to the rule. A dark-eyed blonde is often a piquant beauty. It was a perception of this fact, probably, combined with a love of variety, that induced the brunettes of the Roman Empire to bleach their hair or to wear wigs made of the blonde tresses of German girls.

The skin of babes of sound constitution is very prone to attacks of rashes and eruptions, in consequence of internal disorders, especially those of the alimentary canal. Disturbances of the stomach and bowels are soon reflected upon the skin in the form of erythema, herpes, eczema, seborrhœa, or urticaria. Among those unfortunate children who inherit grave constitutional ailments—such as scrofula or syphilis—the participation of the skin and its appendages is strikingly apparent. Scaly, papular, tubercular, or pustular lesions, actual destruction of portions of the integument *en masse* by ulcerative process, a wan, pasty, earthy, or withered appearance, and inflammation surrounding the root of the nails, are among the affections of the skin which betray the influence of a great and peculiar impairment of nutrition. The teeth of syphilitic children are imperfectly developed, and their cutting edges look as if they had been chipped transversely. In scrofulous patients the hair is often dry and lusterless. Acquired syphilis sets its characteristic seals upon the integument so that “he who runs may read.” The hairs being no longer supplied with wholesome aliment, a more or less universal alopecia ensues, while not infrequently, among its secondary results, we find inflammation of the bed of the nails. A number of cutaneous diseases result from the rheumatic or gouty diathesis, the perverted metabolism which lies at the foundation, particularly of the latter affection, proving a prolific source of modifications of sensibility, as well as of gross pathological changes. Pigmentary alterations may be due to these influences. The intimate connection between the skin and mucous membrane is strikingly exemplified in scarlatina, in which pharyngitis is as characteristic as erythema, and in which also, during and immediately after the eruptive period, gastritis occurs with thickening, grayish exudation, and blood extravasation from softened and ruptured vessels. A little later the genito-urinary mucous membrane is invaded. The falling of the hair caused by the essential fevers, especially by typhoid, is also an excellent instance of the relation between general nutrition and that of the skin. Indeed, it is a suggestive fact that nearly every variety of idiopathic fever is characterized by its specific form of eruption. A harsh, dry, dirty aspect of the skin often betokens the imperfect digestion of fatty articles of food, and the same cause may lead to urticaria, eczema, or erythema nodosum. Sudden, distressing flushings of the face and breast are often found in the victims of



dyspepsia, especially in women at the climacteric period. Urticaria, also, may accompany jaundice, ague, or disordered menstruation. Jaundice likewise gives rise to lichen, and sometimes to boils and carbuncles. The connective-tissue neoplasm, termed xanthoma or vitiligoidea, is very often associated with disturbance of the functions of the liver and with migraine. Graves describes a case in which acute rheumatism was followed by hepatitis with jaundice, and this by urticaria. Pruritus ani is well known to be very common in liver trouble. The bronzing which takes place in Addison's disease is a remarkable example of the effect exerted upon the cutaneous envelope by a general disorder which involves the composition of the blood.

Whatever depresses the health of the skin is liable to alter that of the hair and nails, which are modifications of the cuticle. I have already adverted to affections of those appendages in scrofula and in syphilis. Noticeable though less distinct changes in the nails, consisting of transverse lines or furrows, are indicative of the occurrence of constitutional disorders, and have been remarked by Beau, Wilson, and, more lately, have been studied by Longstreth. It is well known that the nails sometimes loosen and drop out in the beginning or during the course of diabetes mellitus.

Anxiety may be the indirect cause of skin disease by depressing the general nervous vitality, by inducing capricious activity of the sympathetic or vaso-motor system, and by the nervous dyspepsia which it produces. Chambers relates a case of cutaneous anæsthesia in a gentleman who suffered from indigestion which came on after failure in business. The symptoms simulated ataxia, since, from the impairment of the sense of touch, the patient experienced difficulty in adjusting his buttons and would trip over small objects in his path. Under appropriate treatment addressed to his digestive system he entirely recovered. Another, direct and local, effect of anxiety upon the skin is the production of premature wrinkles. Temporary wrinkles are caused in adult life by the play of the facial muscles, and in old age by atrophy of the cutaneous and subcutaneous cellulo-fatty tissue. They may, however, be prematurely induced, and in this case, next to the removal of the exciting cause, may be ranked as a remedial measure inunction with lanolin or other unguent which will improve the nutrition of the territory by which it is absorbed.

The health of the skin is best maintained by a sufficiently plentiful, digestible mixed diet. So true is this that a treatise upon the health and care of the skin requires a careful consideration of the subject of the nature and the mode of preparation of foods, since, as is well known, different modes of preparing alimentary substances affect the readiness with which these are elaborated. Some knowledge of cookery is no less useful to the dermatologist than to the general practitioner, and an occa-

sional reference to the writings of Soyer and Brillat-Savarin would not be wholly profitless. Affections of the stomach and bowels need a wisely selected diet, and if, as is often the case, such affections lead to disease of the skin, our success in removing the latter must be largely dependent upon the manner in which we treat its cause. A number of substances generally well borne create, in some people, sudden and severe digestive disturbances, promptly followed by cutaneous outbreaks. Urticaria, the commonest form which these attacks assume, results sometimes from temporary indigestion, while at others it is the consequence of chronic gastritis. Eczema and erythema nodosum, also, are not infrequently produced by errors of diet. In hysterical women, derangement of the alimentary canal is especially liable to bring on cutaneous eruptions. Chronic eczema, like urticaria, is sometimes directly originated by certain articles of food, such as nuts, cheese, rich dressings, etc. The disfiguring condition known as rosacea is often a result of the liberal use of alcoholic beverages, but it is the concomitant of the stomach, however induced. Gluttony, no less than intemperance, is capable of producing the latter. Acne is another malady which may be induced by digestive failures. Indigestion of fatty substances will often be followed by an eruption of this nature. From what has been said, a practical precept may be deduced, namely, that in treating disease of the skin the habits of the patient as regards the use of spirituous liquors should be under the careful supervision of the physician. It is, in fact, but seldom that such liquids are of advantage in this class of maladies. Even in those disorders—and there are many—associated with general debility and lowered nutrition, although alcohol may act as a spur to a jaded stomach, yet tonic medicaments and a generous regimen secure more permanent benefit. Even beer frequently occasions relapses in eruptions which had been progressing favorably. On the other hand, much that may be urged against alcohol may with equal reason be said of the excessive use of highly nitrogenized substances. In this country much more animal food is habitually consumed than is necessary for the support of the economy. The consequence is that an unnecessarily severe burden is placed upon the liver, the kidneys, the bowels, and the skin. This burden must sooner or later result in disease of one or more of those organs. A temperate, mixed diet, then, avoiding a predominance of meat; an avoidance, comparative or absolute, of alcoholic fluids; sufficient mastication; an abstention from assiduous physical or mental labor directly after a substantial meal; assurance that the eliminative functions are properly performed—are corollaries from the foregoing remarks, and apply to the nutrition of all organs and tissues, skin included. And when I speak of regulation of diet I cordially agree with the caution that the late Professor Flint has uttered upon this subject. Our suggestions should be so made as to avoid lead-

ing the patient to observing too carefully, to pondering too intently, upon his own digestive functions.

The importance of a regular action of the bowels to the health of the system at large has been recognized from time immemorial. Every advance of knowledge, however, leads us to appreciate more highly the depurative effect of the alvine discharges, and Sir Andrew Clarke has lately, under the name of *faecal anæmia*, depicted the evils which result from habitual constipation. As the skin is fed by the blood, so must the blood be fed, steadily and continually, in order to replace the elements which have been abstracted from it by the skin. New matter is introduced from without by means of food; upon this point I have spoken at sufficient length. I have alluded to the removal of waste products which the skin, with other tissues, throws into the circulation. But both the assimilation of nutrient substances and the rejection of excrementitious material require the presence of oxygen in order that they may be consumed. Obtained by ordinary respiration in sufficient quantity for ordinary needs, no organ can long be maintained at a maximum degree of health unless the oxygen supplied be as free as possible of deleterious admixture. Open air, sunlight, and exercise are absolutely necessary to health. Exercise assures an abundant supply of oxygen, a proportionate activity of elimination, and promotes nutrition. The skin partakes of these benefits. Exercise should be proportioned to the general strength of the individual, should be of an agreeable character, and be taken in moderation. The form is of secondary importance; in fact, a variety of forms is best adapted to secure the desired results. As regards invigoration of the muscular system, it is advisable that a combination of methods should successively train different groups of muscles. The daily occupation of those engaged in various species of active labor involves a sufficient amount of exercise, but those devoted to sedentary pursuits, especially students, must dedicate some portion of their time to physical activity. Walking, horseback riding, leaping, running, foot-ball, bicycling, rowing, boxing, fencing, the trapeze, swimming—some or all of these should be reasonably cultivated. It is not necessary, as far as the health is concerned, that the proportions or the strength of an athlete should be gained, but enough open-air exercise should be taken every day to quicken oxidation. A brisk walk is within the power of every one, and, if circumstances render other forms inconvenient or unsuitable, should be taken every day irrespective of weather, except that in the heat of a summer day direct exposure to the rays of the sun should not be too long continued, especially in a hot climate. In the temperate regions, as long as the perspiratory glands perform their function, robust subjects may exert themselves actively without injury; but those who are not rugged may exhaust themselves, which, of course, will render their efforts of no avail. Exercise should never be unreasonably

prolonged, should never be prosecuted merely as a task, nor ever undertaken while the nervous strength is chiefly employed in the work of digestion. The games and romps of the young necessitate abundant exercise, while old age forbids strenuous physical effort.

Healthy activity should be succeeded by healthy repose. Cells and fibers are worn out by exercise, and can only be replaced by the quiet vegetative processes which go on during rest and sleep. Sleep, therefore, is a hygienic measure which concerns the skin no less than the nerve-centers. The amount of rest should depend upon the needs of each individual system, and should not be regulated according to any rigid rule. As with most people refreshing slumber can only be obtained when the mind is comparatively free from anxiety, serenity of disposition should be cultivated as an element favoring the health of the skin. Cutaneous disturbances of sensibility or of circulation are often the outcome of long-continued mental strain. Cheerfulness in itself is a great blessing, physical no less than mental. It favors the elaboration and circulation of the blood, the proper action of the heart, and the vigor of the entire organism. Indeed, in a comprehensive survey of the subject of hygiene as applied to the skin, we are scarcely going too far in considering the co-operation of good moral habits as having a favorable influence. At any rate, we may subscribe to the opinion of that master of olden time, who relied a good deal upon the assistance of "Doctors, Diet, Quiet, and Merryman."

*(To be concluded in November number.)*

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### A CASE OF ACNE INDURATA.

By B. MERRILL RICKETTS, M. D.,

Professor of Dermatology and Syphilography at the Cincinnati Polyclinic, etc.

THE accompanying photograph is that of a man almost twenty-one years of age, five feet and eleven inches high, weighing one hundred and forty pounds.

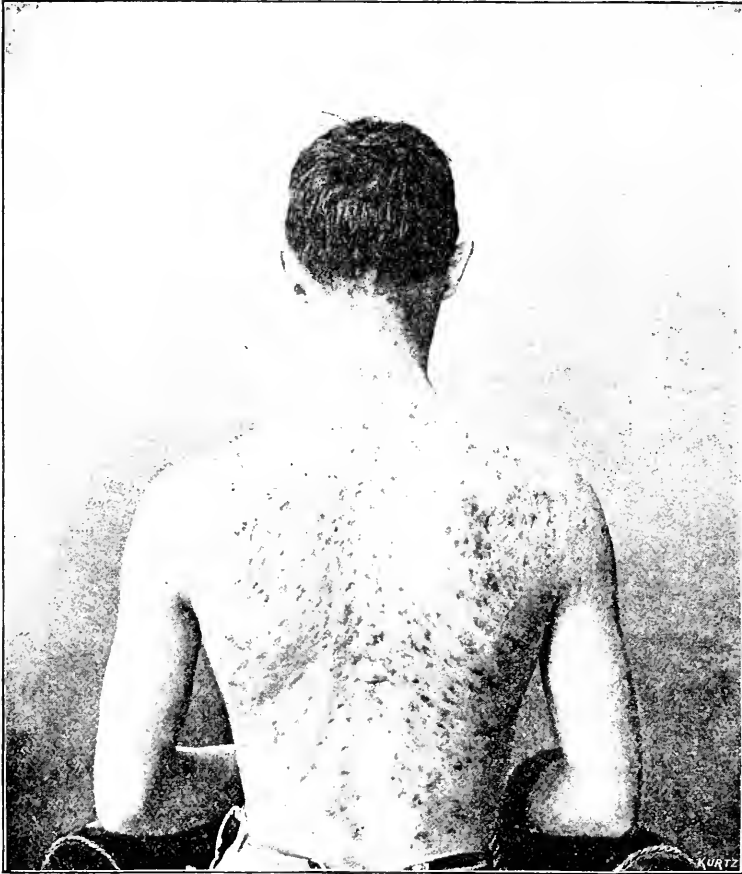
He has a pretty good constitution, great endurance, and considerable strength, having never been seriously ill or suffered from any but trivial ailments.

The acne began at the age of seventeen years in the form of pustules upon the vertebra prominens; some of them were so large that his mother called them boils.

The father, being a physician, opened them, but found no central slough. From this time on he lost sight of the son as a patient until his attention was called to it during the past summer (July, I believe), when he consulted me.

The result of this neglect has been the spreading of the disease until the skin covering the posterior aspect of the body, extending from the occiput to the buttock, has become involved.

The destruction of tissue has been extensive, especially where there has been burrowing with union of two or more pustules.



Where this has occurred the skin has been replaced by cicatricial tissue very much depressed and discolored, giving to it and the immediate surrounding tissue a coppery color. One or two of these will measure as much as one inch in diameter. The greatest destruction of tissue has been upon the right scapula and immediately over the spinal prominences, extending from the first to the twelfth dorsal vertebræ. This I consider due to the irritation produced by the pressure while lying upon the back.

There has also been an extensive lesion in the hair, which I opened several times, evacuating quite a considerable amount of a green-tinted pus. The hair follicles at this point have been destroyed, leaving, as you see, the white cicatricial tissue.

The disease has not at any time been very extensive upon the face—indeed, not enough to attract or demand special attention—and, so far as his general appearance is concerned, would not be considered as one suffering from this terrible attack of *acne pustulosum*. I say terrible, for I have never seen such havoc from the disease as has taken place in this case.

The treatment has been simple and by some considered severe, but, being upon the skin of the back, there is but little pain or discomfort in the use of the knife.

Every pustule and elevation was punctured and the contents freely evacuated. In some of these the contents would be semi-solid while in others a bloody serum would be found, especially upon opening one that had been previously cut with or without finding pus.

The color of the skin will indicate whether or not the lesions contain fluid. Besides, there is a sharp pain and a point of tenderness upon pressure that will serve as a safeguard.

Some of these contained soft sebaceous matter, some contained a gritty mass of hard secretion which seems to have undergone a calcareous change, and some of the follicles were occupied by the hardest of collections of epithelium, with little or no sebaceous material.

The young man's father states that he has opened almost if not quite one thousand of these lesions during the few weeks he was at home—the young man having returned to college, where he now is. With the treatment he took *kali iodidi*, cod-liver oil, and plenty of exercise and nourishing food. He also resorted to massage with good results, in that he has not had any pustulation resulting in the loss of tissue. His general health has greatly improved and he does not suffer from the pain and annoyance he formerly did. I do not know that I have ever seen a case of *acne* of any kind make a more rapid or more satisfactory recovery than the foregoing one.

He is now under the care of my friend, Dr. George H. Rohé, of Baltimore, who states that his patient's condition continues to improve.

The father claims to have had a severe attack of *acne* when from seventeen to twenty years of age, and that besides the young man there is a daughter who is now at the age of eighteen suffering from *acne facialis*.

93 EAST FOURTH STREET.

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## Society Transactions.

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### THE INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY.

THE first International Congress of Dermatology and Syphilography which was held in Paris, August 5th to 10th, was not attended by so large a number of American dermatologists as might have been expected, and several of those who had anticipated taking part and had even gone abroad were prevented by sickness or other circumstances from taking an active part in the meetings.

Those who were present to represent this country were Dr. James C. White, of Boston, who presided at one of the meetings; Dr. J. Nevins Hyde, of Chicago; Dr. Klotz, of New York; and Dr. Morison of Baltimore. The papers read by these gentlemen were upon the subjects "Hereditary Dermatoses," by Dr. White; "Observations based upon the Statistics of Cutaneous Diseases in America," by Dr. Hyde; and "On the Formation of Pigment in the Skin of the Negro," by Dr. Morison. The French language was usually employed, although French, German, and English were all official. Austria was well represented, Kaposi, Neumann, Finger, Hebra, Riehl, Schiff, and Schwimmer, of Pesth, all being present. The first subject discussed was that of **The Lichen Group**, over which there has been such a diversity of opinion in the different countries. The question to be determined was whether Hebra's lichen ruber was identical with Kaposi's lichen acuminatus, and what place in the group the lichen planus of Wilson held. Kaposi said that in Willan's time all eruptions of small papules were called lichen, just as at the present day we speak of lichen syphiliticus, lichen pilaris, lichen urticatus, etc. Hebra first attached a nosological sense to the word lichen, and described under it two forms of disease—lichen ruber and lichen scrofulosorum. The first was accepted without hesitation down to 1874. At the present time Besnier, for instance, thinks that pityriasis rubra pilaris should be distinguished from the lichen ruber acuminatus of the Americans, from the lichen ruber of Hebra, and, finally, from the lichen ruber acuminatus of Unna. He was surprised to find, therefore, that we had three different kinds of lichen ruber acuminatus, but desired to add a fourth—that of Kaposi, because he had preceded all the others. Not that he wished to claim priority, but the responsibility of the name, and to distinguish it from the form described in 1869, by Wilson, under the name of lichen planus—a disease which is but a simple variety of lichen ruber. The greatest difficulty has recently arisen from French authors who have separated pityriasis rubra pilaris, and made a distinction between it and his lichen ruber acuminatus or the lichen ruber of Hebra, and he found himself unable to accept the distinction. They affirm that the hyperæmia and cellular infiltration of the papillary bodies are accessory; that the hyperkeratosis is, on the contrary, primitive; but he can not attach importance to these statements.

In conclusion, he believes—

1. That lichen ruber (Hebra) corresponds absolutely with his lichen ruber acuminatus.

2. That this disease is absolutely different from the pityriasis ruber of Hebra.

3. That the forms described by Besnier, Boeck, and others, as pityriasis pilaris and pityriasis rubra pilaris are identical with his lichen ruber acuminatus. Not having seen a living case, but basing this opinion merely on descriptions and representations, he reserves his final decision. In excessive cellular infiltrations special forms are seen such as he has described as lichen ruber moniliformis, and others, which are analogous to mycosis fungoïde and hyperkeratosis, may cause a resemblance to ichthyosis. Hebra, Boeck, Jamieson, Besnier, and others opposed Kaposi's view as to the identity of lichen ruber and pityriasis rubra pilaris.

Hallopeau said that the name lichen should be reserved for the disease described by Wilson, which should be called simply lichen, for the denominations ruber and planus did not always apply to it, the latter only in one variety. In conclusion, he thought the lichen group artificial, and that it was too arbitrary to make diseases enter it which had nothing in common but the papular aspect of their elements. An acute and a chronic form should be admitted, the former including a part of the cases published under the name of lichen ruber acuminatus.

Little support was given by those who took part in this discussion to the view generally held in America that there is an absolute distinction to be made between lichen ruber and lichen planus, Besnier stating that the lichen ruber of the American school was only their pityriasis rubra pilaris. Some observers who spoke had seen typical lesions of each of these forms in the same patient.

Unna regarded the two affections as distinct, but he thought there was a certain confused idea prevalent regarding them. He could not regard the affection described by Kaposi as the same one described by Hebra. The latter he regarded as a trophoneurotic affection, while that of Kaposi was the same, in his opinion, as the pityriasis rubra pilaris described by Devergie. Schiff thought Hebra's lichen too severe to be regarded as a trophoneurosis, and that it was really a constitutional disease.

Schwimmer thought it a pure hypothesis on Unna's part that the lichen acuminatus was a trophoneurosis. He, too, thought it possible that pityriasis rubra pilaris and lichen acuminatus were the same thing.

Neumann insisted upon the reality of a lichen scrofulosorum, but Besnier said it was not a lichen at all, but an aene, and that in the scrofulous the dermatoses are very diverse.

**Pityriasis Rubra.**—In discussing this question, Kaposi again took very positive ground, and upheld the views advanced by his master, the elder Hebra. A most extensive experience in his specialty could alone enable a man to identify as a specific affection that to which the name was strictly limited by Hebra. A fatal result was one of the prerequisites to a positive diagnosis. Those cases were not included which showed merely redness and fine desquamation of the surface, with some infiltration and possibly asso-



ciated with cachexia, but in which recovery took place. Here, as in the discussion of lichen, no one was able to bring another to his way of thinking, and the question was left much in the same condition in which it was taken up.

DR. PÉTRINI, of Bucharest, opened the discussion. He thought generalized primitive exfoliative dermatitis, recurring scarlatiniform erythema, and pityriasis rubra of the type Hebra were distinct dermatoses. Microscopic examination he thinks gives the key to the permanent exfoliation of pityriasis. He has found arterial lesions progressing even to obliteration of the vessels, which are sufficient to explain the changes of nutrition. Scarlatiniform erythema is a rare affection, and must not be confounded with medicinal rashes, which are never generalized and never recur. An augmentation of the stratum granulosum explains the desquamation present. Generalized primitive exfoliative dermatitis does not constitute the acute form of pityriasis rubra of Hebra. It gets well, though slowly.

DR. BROCC thought the generic term pityriasis rubra could be preserved for (1) desquamative scarlatiniform erythema or acute benign exfoliative dermatitis; (2) generalized exfoliative dermatitis proper or subacute; (3) chronic dermatitis; (4) chronic pityriasis rubra of Hebra; (5) subacute or benign pityriasis rubra. The reader then passed in review the characteristics of each of these five types, and, from the manner in which his work was received, it was evidently considered a valuable contribution to the Congress.

DR. CROCKER related a case of generalized exfoliative dermatitis which developed subsequent to a psoriasis. The hair and nails fell, but the patient made a good recovery.

DR. JAMIESON thought the term pityriasis rubra only expressed one phase of a generalized exfoliative dermatitis which could be consecutive to an eczema, a psoriasis, a pemphigus, or a lichen. It presented itself under two forms—the dry variety, with small scales, and the moist variety, with large scales.

DR. UNNA said that up to the present time he had seen six cases of pityriasis rubra of Hebra, four in which there were *at the end* all the symptoms, and only the symptoms, that Hebra had fixed upon as pathognomonic of this disease. But among these four there were three in which he observed the disease develop after a seborrhœal eczema very well marked, and only one in which the disease began with the more simple symptoms (diffuse redness, generalized, and without plaques), as Hebra has pointed out. These three cases all died after the course of a few years, while the single one which at its onset followed Hebra's type got well after prolonged treatment. He had seen, besides, two cases of seborrhœal eczema which he thought had become transformed into the pityriasis rubra of Hebra. They are still alive. He believes, therefore, that there are two modes of début.

DR. VIDAL had seen a case which confirmed the former speaker's views on seborrhœal eczema and pityriasis rubra. The case which was diagnosticated seborrhœal eczema became rapidly generalized and invaded the whole surface of the body at the same time that the peculiar sebaceous odor became noticeable. Scales then formed characteristic of pityriasis rubra, progressive weakness came on, and the patient died.

DR. SCHWIMMER regretted the confusion that such views could cause. The English and French admitted a disease which they called pityriasis rubra at

the beginning of this century, but they considered it a form of eczema. Hebra's disease is absolutely special in its gravity, evolution, etc. He thought, however, the prognosis was too dark, and that much could be hoped for from treatment even in advanced cases.

DR. HEBRA spoke of the great rarity of the affection and the difficulties of diagnosis. He was glad Dr. Schwimmer had warned against the confusion which would take place if Unna's ideas were adopted.

DR. BESNIER thought Hebra's type was and should be generally accepted with all its characteristics. He gave Hebra full credit and read from the works of Devergie to show that what he described under the name *pityriasis rubra* has nothing in common with the description of the former.

**Pemphigus; Bullous Dermatoses.**—Under the discussion of this question Duhring's dermatitis herpetiformis came in for a full share of attention, and we regret that our honored countryman should have been detained in London by illness. In his enforced absence, however, there was an able and willing champion who, though himself forced to quit a sick-bed to present his arguments in favor of this group, still made a strong claim for its recognition, and presented the views he holds upon the subject in such a forcible manner that it may be said to-day that dermatitis herpetiformis is recognized in every country as a distinct affection, and it is a matter for self-congratulations that, despite much opposition, the work of this American dermatologist has been so well appreciated. Kaposi does not at all accept Duhring's disease. He says it is not an entity, that Duhring has already withdrawn impetigo herpetiformis, and that it will be the same with all the other types as we learn better how to diagnosticate them. Thus the group will become smaller and smaller until finally it contains nothing. Pemphigus will cover some cases, polymorphous erythema others, and no morbid entity is left to which the term Duhring's disease can be applied.

DR. SCHWIMMER said that before Duhring the disease to which he has given the name dermatitis herpetiformis was known and described under various terms. He would not, therefore, give this new denomination to affections well described as bullous or vesicular erythema, for example, but would keep it for a definite type characterized by vesiculo-bullous eruptions which are generalized, pruriginous, and lasting. He did not agree with Kaposi that all bullous affections should be called pemphigus.

DR. BROcq read a letter from Dr. Duhring, in which he insisted upon these four cardinal characteristics: 1. Very marked polymorphism of the eruption. 2. Constant painful phenomena. 3. Long continuance of the eruption (months, years—ten, twenty years and more). 4. General good condition, despite the intensity of the eruptive phenomena.

DR. UNNA agreed with Brocq that a distinct clinical type meriting the name did exist, but since all the forms of hydroa are included in it he did not see why it should not be called hydroa. The tendency of the Congress seemed to be to acknowledge the soundness of Duhring's claims, but to withdraw from the group he has made many morbid conditions which have been included, possibly by an excess of enthusiasm. So far as the name goes, little importance is to be attached to that, so long as the condition is recognized and understood.

**Pemphigus Vegetans.**—DR. NEUMANN read a memoir upon this disease, whose nature is quite enigmatic and whose diagnosis is attended with much difficulty, being in its early stages often confounded with syphilis. The prognosis is very grave. At first the bullæ are lentil-sized, and the epidermis falls spontaneously. Whitish elevations replace the bullæ, assume an irregular, warty appearance, and become surrounded by a zone of minute bullæ. The mucous membranes may not be spared. Continuous baths give the best therapeutic results.

**Cutaneous Psorospermiosis.**—A patient was exhibited before the Congress who illustrated in an excellent way a valuable paper by Darier, a *résumé* of which will be found in another part of this Journal. The man's body was covered with wart-like elevations, associated with proliferation of tissue in and about the sebaceous glands. Dr. White, of Boston, who has recently written upon the subject of keratosis follicularis, was present and established the identity of this with his own case.

**Trichophytosis.**—DR. BUTTE communicated to the Congress a new treatment for tinea tonsurans—a one-per-cent. ointment of the protochloride of iodine, which effects a cure in from three to five months without necessitating epilation.

DR. QUINQUAND spoke favorably of this method, and also of the curette for removing the most parasites possible, followed by bichloride lotions and subsequent epilation.

DR. BESNIER thought this procedure might cause dermatitis and permanent baldness where the alopecia of itself never did.

DR. VIDAL says epilation is an illusion; only the sound hairs can be pulled, as those diseased break off. The only indication is to prevent new foci of disease from appearing.

It was the opinion of several speakers that the disease is more prevalent in Paris than in Vienna.

**Spontaneous Keloid.**—DR. DE AMICIS, of Naples, presented a case of spontaneous keloid in a neurotic woman upon whose body three hundred and eighteen tumors were counted. The tumors were small, rose-colored bodies without ramifications, which might be confounded with sarcoma. There had been complete absence of preceding traumatic lesions. Differing from cicatricial keloid, the epidermis was not involved, but they arose from the middle of the corium. No microbe could be found. The nervous system was evidently at fault, as shown by the symmetry, the special evolution, and the neuropathic condition of the patient.

**Formation of Pigment in the Skin of the Negro** was the title of a paper presented by DR. MORISON, of Baltimore. The author said it was generally believed that negroes are born white. This is an error, but the question is more difficult of solution than one would think, and those who attend negro women in their confinement make the most contradictory statements. Histological examination solves the question in the negative. No matter how white the skin may appear to the naked eye, the epidermis contains quite a large amount of pigment, which soon takes on a much more considerable development.

(To be concluded.)

## Selections.

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### Raynaud's Symmetrical Gangrene in a Patient suffering from Constitutional Syphilis.

DR. J. E. MORGAN relates the history of a case in the "Lancet" of July 6th to 27th, and gives some remarks on the history, nature, and manifestations of the disease which now goes by the name of Raynaud. The patient in question enjoyed robust health until six years ago, when he contracted a hard chancre, and remained under treatment for six weeks. He subsequently suffered from secondary symptoms for a year, following which he was well for three years, when he was treated for ulceration of the fauces and soft palate. Fifteen months later excruciating pains appeared in different parts of the body; sometimes they were especially severe in the lower extremities. The pains appeared to be within his bones, and were aggravated at night, but finally ceased, and were succeeded by a severe tingling sensation in his fingers and in his ears, which burned and itched as though they had been stung by nettles. Icy coldness of the parts followed, and tactile sensation in his fingers was entirely lost. There was both anæsthesia and analgesia. The coldness of the fingers lasted for five or six weeks, the parts feeling icy to the touch and looking white and bloodless. The fingers of both hands were affected, one a few days after the other, not even the thumbs escaping. After six weeks the tips of the fingers assumed a livid, bluish shade, and turned black in the course of a few days more. The nails were also black, excepting the lunula, which took on a slaty hue. The sensation changed from that of numbness to pain when the parts became blue, and became intensified as the inky-black color came on. On the palmar surface a zone of congestion extended half way round the base. Soon after the fingers became blue the ears were likewise affected, the tip of the nose was of a bluish-black shade, and the *ala nasi* looked purple and congested. A portion of the helix of the right ear sloughed away, and the skin over the backs of the fingers separated, showing destruction of the derma and ulceration eroding the deeper structures. Iodide of potassium and *liquor hydrargyri bichloridi* was administered in moderate doses with immediate good effect. The black parts became blue and subsequently of a greenish-yellow tint, and healthy granulations followed the sloughs. The urine contained blood on one occasion, but no albumin or sugar was ever found. No change was discoverable in the radial or other arteries of the arm. The patient was discharged about a month later comparatively well. The extremities of the fingers had become thin and tapering. Three months later violent pains in the head began to appear, attended with a mazed condition and dimness of vision. Antisyphilitic treatment was again ordered, and benefit was no less marked than before. The author regards the case as one of Raynaud's disease in a patient thoroughly tainted by syphilitic poison. He has, since observing this case, collected ninety-three from English, American, and continental publications,

but has been unable to find another instance where the symptoms were so directly associated with those of acquired syphilis. Raynaud, in his original thesis, refers to two cases out of twenty-five in which the patients had suffered at some time from syphilis. Dr. Young brought a case complicated with congenital syphilis before the Manchester Medical Society in October, 1884. Dr. Humphreys related to the author a case of a young girl of nine years in whom gangrene destroyed the two terminal phalanges of the toes, and the patient died some weeks later of congenital syphilis. Mr. Taunton records in the "British Medical Journal," vol. i, 1864, the case of a boy of ten who suffered at different times from gangrenous patches of both ears, and in whom there was a distinct syphilitic taint.

Mr. Puzey reported in the "British Medical Journal," 1874, the case of a man who, after contracting syphilis, had the glans penis to shrivel up and become dusky, and the skin to become cold and dark. The whole circulation was very feeble, the nose frequently turned blue, and the tips of his fingers were exceedingly tapering.

In the two cases of brother and sister reported by Mr. Makins in the "St. Thomas's Hospital Reports" there was a doubtful history of congenital syphilis. Englisch reported a case in the "Wiener med. Wochenschrift" where a syphilitic taint was suspected in a woman with gangrene of both feet. Among the cases collected by the author as proper to classify as Raynaud's disease are several which are long anterior to Raynaud's time. One of the latter's cases dates back, however, to 1629. This author thoroughly worked out the difficult problem of ætiology. He showed that in many instances there are three stages: The first, of icy coldness and pallor, local syncope, usually paroxysmal. The second stage, of local asphyxia, the blood stagnating in the extremities. The third, that of gangrene, when mortification occurs. He showed that there could be no closure or obstruction within the arteries due either to arteritis or mechanical obstruction, because an injection made into a corpse penetrated readily and fully into all the gangrenous parts. He further proved that it was not due to congenital or acquired narrowing of the caliber of the arteries, that it was not dependent upon embolism, and that it was altogether distinct from diabetic gangrene and gangrenous ergotism. Dr. Morgan attributes the rarity of this disease to the relative small number of individuals possessed of constitutional peculiarities which render them abnormally susceptible to impressions which in the vast majority of persons would pass wholly unheeded. A very large proportion of those who have suffered from Raynaud's disease are described as emotional and excitable, with the neurotic element in the ascendant.

Still he is disposed to believe that vascular spasm, even though maintained for a considerable time, is not by itself alone sufficient to induce gangrene. It may and does in countless instances induce local syncope, and far more rarely asphyxia, but not gangrene. This destructive change requires a degraded vitality in the cell structures affected, and when the functions of the trophic nerves are suspended, destructive changes are liable to occur. To understand anomalies in the circulation of the extremities, we must remember what physiology has taught regarding the manner in which each capillary area has its own minute nervous system. In the words of Raynaud,

"each part is united to the whole by the common conditions of the general circulation, and at the same time by means of the nervous system; each part can have a circulation of its own and become physiologically individualized." An attentive study of the different stages of this disease the author thinks will lead to the belief that in local syncope, when the ischæmia is extreme, arteries, capillaries, and venules are alike affected by the spasmodic contraction, and are all firmly contracted. After a time, however, when asphyxia succeeds, the veins, to which the muscular elements are more sparingly distributed, are the first to dilate, the latter remaining impervious. From a study of the cases collected by the author it is seen that the lesions differ greatly, and it is, he thinks, reasonable to assume that those changes in the nerves on which they are believed to depend differ also in gravity. In some cases the exciting cause acts directly on the minute ganglia situated over the vessels. In other instances pains are experienced radiating centripetally in the direction of the cord. Again, the motor nerves may be affected, as well as the sensory and vaso-motors, and peripheral neuritis may be observed. Reference is made to a case associated with anterior spinal paralysis reported in the "Medical Record" of April, 1878, by Dr. T. A. McBride, and to numerous instances occurring in the insane, several of which are to be found in an article by Dr. Shaw, of the Kings County Insane Asylum, published in the "New York Medical Journal" in 1886. If, then, the lesions connected with this disease are so multifarious, it is but reasonable to expect that its manifestations should be proportionately varied and uncertain. In the ninety-three collated cases, ague is alluded to five times as one of the diseases preceding the gangrenous paroxysms, and attention is called to the significant fact that the great value of quinine in treating Raynaud's disease has been insisted upon. In a number of instances the vision was affected at the time of the attack, and in the author's own case sight was strangely affected, objects appeared dim, and looked to the patient "as he had been accustomed to see them when under the influence of drink." Examination showed a narrowing and constriction of the arteries of the retina. In some of Raynaud's cases visual disturbance was noted. Epilepsy, hemiplegia, aphasia, loss of consciousness, a dazed condition, etc., noted in many of the cases, make it reasonable to assume that the disturbance of the blood-supply as seen in the hands and feet was initiated in the vessels of the brain. Fifteen of the cases were known to have died while under observation, several deaths being due, however, to intercurrent illness. In eight instances only one extremity was affected, and for them at least the term "symmetrical gangrene" is inappropriate. The author thinks no better name can be given to this most interesting condition than that of Raynaud, to whom we are indebted for almost everything we know regarding its ætiology and pathology.

### **Psorospermose Folliculaire Vegetante.**

UNDER the above title Dr. J. Darier, chief of the laboratory of the St. Louis Hospital in Paris, makes an interesting anatomo-pathological study of a cutaneous affection which has hitherto not been described or comprised in one of the groups of acne (sebacea, cornea, hypertrophica) or of keratosis (ichthyosis) follicularis, etc. The original article is published in the July number of

the "Annales de dermatologic," 1889, and is illustrated by two excellent colored plates. The affection appears to be quite a rare one, and the paper is founded upon the observation of but two cases. The author, as well as Dr. Thibault, who incorporated in his graduation thesis ("Thèse de Paris," May 8, 1889) some of the observations which they had made together, finds a certain analogy between the reported cases of keratosis follicularis, acne sebacea, cornea, etc., found in literature and their psorospermiosis, but the insufficient histological data furnished do not permit them to decide whether this analogy is apparent or real.

The lesions of follicular psorospermiosis are common to all parts of the body's surface, but there are points of election where they attain their greatest development; these are the scalp, the face, the presternal region, the flanks, and especially the inguinal regions. In its first stage the elementary lesion is a small papule surmounted by a brownish or grayish crust which is elevated, thin, hard and dry to the touch, and firmly adherent. When you have succeeded in removing it, you see that it is a veritable little horn incased in a funnel-shaped depression by a conical extremity of dirty-white color, semi-soft consistence, and fatty feel.

At the points of confluence of the lesions there is found upon the skin a brownish or earthy-colored layer, more or less fatty to the touch, and there is a series of closely-packed, irregular elevations, which give to the hand the sensation of passing over a file. Hypertrophic, reddish elevations the size of a lentil, a pea, or even larger, having a central depression, are at times found from which can be pressed sebaceous matter, either pure or mixed with pus.

These elements become grouped and confluent, forming voluminous masses—in fact, veritable tumors. These are mostly observed in the hypogastric region, the fold of the groin, and in the anal region.

These tumors correspond with a more advanced stage of the early lesion, which, as we have seen, is a simple papule surmounted by a peculiar crust, and histological examination shows their absolute identity. The same changes were found in particles excised from both patients. The lesions have their principal but not exclusive seat at the neck of the pilo-sebaceous follicles. As is well known, the structure of the walls of the follicle in the portion above the opening of the sebaceous gland is quite different from that below. In what Besnier calls the *canal pileaire* neither internal epithelial sheath nor external sheath is to be distinguished, but there is instead an epidermic covering altogether similar to that of the surface of the skin—that is to say, composed of a Malpighian layer, a stratum granulosum, and a horny layer, which is in contact with the hair, and we can say that the neck of the follicle is only an invagination of the epidermis. Now, the neck of this follicle is dilated and filled with a horny-appearing substance which rises up from the bottom of the excavation and projects from the external orifice. The hair is preserved and traverses the mass or passes to one side of it.

The follicular keratoses, such as follicular ichthyosis, lichen pilaris, and pityriasis pilaris, in which the canal is obstructed by horny cells, is not accompanied by any reaction analogous to that which takes place in this affection, producing a secondary papillomatous budding and sometimes vegetations.

The horny substance was shown by its reactions to differ from the ordinary corneous products of other affections. A great number of the cells in the lower portion of the plug have the aspect of quite round bodies surrounded by a refractive membrane of double contour, plainly marked, which gives them somewhat the appearance of cartilage cells inclosed in their capsule. This membrane contains a granular protoplasm, which often fills it incompletely and in the middle of which is generally seen a nucleus well defined and furnished with nucleoles. These characteristics and the absence of filaments of union permit of easy distinction between these round bodies and the epidermic cells. These bodies are regarded by the author as foreign bodies, or, in other words, parasites—*psorospermies* or *coccidies*—organisms of the class of *sporozoaires*.

As regards the vegetations, an observer not upon his guard would diagnose epithelioma starting from a follicle upon examining the sections showing epithelial cylinders, etc. The sebaceous-like substance which can be pressed out of the tumors is composed of psorosperms in the state of round encysted bodies or of refractive grains, a great quantity of epidermic globes, epithelial cells, more or less altered pus, and bacteria of all kinds.

The *coccidies* which are present in this affection are found almost exclusively in the epithelial tissues of vertebrates, where they are met with in the interior of the cells themselves. They are distinguished from the *sporozoaires* of the other groups, and notably from the *gregarines*, by various characteristics, of which the following are the principal ones : absence of motion at all periods of their development, intracellular habitat, solitary encystment not preceded by conjugation, and a relatively small number of spores which form in the cysts. The author believes that if the opinion of Bollinger upon the nature of the corpuscles in molluscum contagiosum were proved to be correct, the disease which he here describes would not be isolated in human pathology.

Similar round bodies have been found by him in Paget's disease of the nipple, both upon the skin surface and in the subsequently developing cancer, and he has thought that the latter could be attributed to their penetration into the galactophorous canals. The vegetations of almost epitheliomatous aspect in psorospermiosis tempt one to suppose that there is a general tendency in surfaces covered with epithelium to react in this way under the influence of the irritation caused by the presence of these parasites.

No analogous organisms are found in acne or keratosis follicularis, and thus they can not be said to be hosts constantly found in dilated follicles. The following conclusions are given :

1. There exists in man a group of cutaneous diseases which merit the name of psorospermiosis, being due to the presence in the epidermis of parasites of the order of *sporozoaires*, group of *psorospermies* or *coccidies*.

2. In one of these diseases the coccidies of a particular kind invade the orifices of the follicles of the skin ; they present themselves under the form of round bodies, generally encysted and inclosed within epithelial cells, or as refractive grains. Their accumulation constitutes a plug which projects from the orifice of the follicle.

3. The presence of these parasites may serve to establish the diagnosis of



this disease, for they are not met with in any other affection clinically analogous.

4. The neck of the follicles invaded becomes secondarily the seat of papillomatous vegetations which may take on an extensive development and constitute veritable tumors.

5. This disease, which can be called follicular vegetative psorospormosis, should, from an ætiological standpoint, be closely allied to Paget's disease, and very probably to molluscum contagiosum.

### **Arthritis and Blennorrhagic Hydrocele without Gonococci.**

IN an article published in the "*Annales des mal. des organes genito-urinaires*," August, 1889, Professor Guyon and Dr. Janet give four observations showing the absence of gonococci in gonorrhœal complications even in their early stages. The first observation represents the habitual type of gonorrhœal rheumatism coming on after several attacks of gonorrhœa in a subject who has already been affected with other complications. Others show the precocious form occurring with the first attack of gonorrhœa a few days after its onset.

Several traits were found common to them all :

1. The coincidence of disappearance of the urethral discharge with the onset of the arthritis.

2. The absence of rheumatic antecedents in those attacked, either hereditary or personal.

3. The absence of gonococci and of all other organisms in the pathological fluids obtained from the joints as well as from the hydrocele.

Kammerer, assistant at the clinic at Freiburg, saw distinctly in one case of blennorrhagic arthritis microbes similar to those described by Neisser. At the end of eighteen days an incision was made and none were longer found in the liquid. He therefore concluded that the negative results reported were due to the examination being made too late. In these observations, however, the fluid was collected two, five, nine, and ten days, respectively, after the onset.

For these authors the explanation of the various views held by observers is due to the fact that gonorrhœal rheumatism presents itself under two different forms—a subacute and commoner form with serous but not purulent production, and an acute phlegmonous form in which the fluid production is clearly purulent. (This form is exceedingly rare.) The cause of the arthritis does not reside in the presence of the gonococcus itself, but in the action upon the articulation of the soluble products secreted by this microbe from the mucous membrane of the urethra. Suppurative blennorrhagic arthritides are due to secondary infection.

This hypothesis is proved not only by the uncertainties which reign in the descriptions of the authors who have claimed to find the gonococcus elsewhere than in the urinary passages and upon the mucous surfaces of the natural orifices, but also by the observations of Bockhart and Gerheim, who have found in the suppurative complication of blennorrhagia (bubo, periurethral abscess, Bartholin'sitis) not gonococci, but the ordinary micrococci of suppuration.

### The Symptomatic Indication and Therapy of Residual Urine.

CASPER, writing upon this subject in the "Berliner Klinik," No. 7, says : Under the term residual urine we understand that portion of the urine which after urinating remains behind in the bladder. The healthy man has no residual urine—that is to say, he empties his bladder at each act with the exception of a few drops. We possess in the residual urine a measure to indicate the functional condition of the bladder. The lack of functional capacity can be caused by a variety of circumstances—defect of innervation of the bladder, embarrassed or obstructed flow of urine.

Furthermore, degenerative or functional change in the muscles of the bladder may cause a lessening of the contractility of the vesical detrusor (atony of the bladder). Persistent abnormal frequency of urination always leads to the presumption of residual urine being present. The quantity of urine voided shows only the power of secretion on the part of the kidneys and not the expulsive power of the bladder. Involuntary flow of urine almost always indicates an excessive collection of residual urine, a retention of urine, but not incontinence. It is doubtless true that in certain cases of chronic retention catheterization is absolutely to be warned against, but the author endeavors to free it from the suspicion of causing in many cases severe cystitis and even the death of the patient. The cystitis is caused in these cases by the introduction of infectious material, while the sudden death is due to the operation having been put off too long. The catheter should be thoroughly cleansed and disinfected and introduced with the utmost care. Soft instruments are preferred. For anointing the instrument, equal parts of lanolin and vaseline well rubbed up together are recommended.—*Med.-chirurg. Rundschau*, Aug., 1889.

### Adenopathies Secondary to Lupus Vulgaris.

DR. LELOIR says it is certain that inflammatory adenopathies may exist in those having lupus without bearing any relation to the tuberculous virus inclosed in the seat of the disease.

To consider, however, as some authors do, that all such glandular swellings, even the caseous glands, are but inflammatory complications, is contrary to the facts as they are observed. Tubercular adenopathies consecutive to lupus must be differentiated from the scrofulo-tuberculoses which may have existed before them. It is certain, however, that there exist in lupous patients adenopathies which are in direct relationship with the lupus. They develop from the invasion of the ganglion by tubercular virus drawn from the lupous region by the lymphatic vessels. Lupous adenopathies have the following characteristics : they are rare ; they are located at the points where the lymphatic vessels running from territory invaded by the lupus terminate in the ganglia ; they appear quite late after the lupus has developed ; they are of tuberculous nature.

In seven cases the author has established the tuberculous nature of these glandular enlargements consecutive to lupus vulgaris. The glands examined were removed during life ; part was examined bacteriologically, and another part was inoculated by intraperitoneal injection in guinea-pigs and

into the anterior chamber of the eye in rabbits. Positive inoculations were obtained in each instance. Caseous suppurating adenopathies are more frequent after lupus exedens. This may be because the lymphatic vessels absorb not only the micro-organisms of tuberculosis, but also the micro-organisms of suppuration.—*Journal de méd. de Paris*, Aug. 11, 1889.

### Treatment of Alopecia Areata.

DR. DUBREUILH, in the "*Journal de méd. de Bordeaux*," August 18, 1889, speaking of treatment in *pelade*, first calls attention to the prophylactic measure laid down by Besnier in his recent report to the Academy of Medicine, in which he strongly recommends that all subjects of the disease be excluded from schools and public institutions so far as practicable.

The curative treatment is uncertain in its results. Some cases recover spontaneously in two months, while there are others that, despite the most vigorous treatment, last for months or over a year. The duration of a treated case is less than that of one left to itself. The methods of treatment are divided into two groups according as the alopecia is of nervous or parasitic origin, and each method has been extolled to the exclusion of others and for all the cases by the adherents of one or the other theory. Exciting frictions of all natures are recommended by the contagionists as by those who only admit of a nervous origin.

Horand advises the application upon the bald spots of pieces of tinder soaked in croton-oil left on long enough to produce vesication. If too much inflammatory reaction is brought about, the hair follicles may be destroyed and the baldness become permanent. Besnier says he has found no good results from any form of electricity. Schütz, on the other hand, has recently reported the greatest benefit in trophoneurotic alopecia by passing a current of four milliampères through each spot for five minutes at a time. Besnier thinks epilation of the borders useful. Lassar believes in the contagious nature of the disease and has the head washed every day with soap, followed by—

R Hydrarg. chl. corros.....	0.50
Glycerini,	
Eau de Cologne .....	ãã 50.00
Aquæ destillat.....	150.00

Then washed with a one-half-per-cent. alcoholic solution of naphthol, and finally rubbed with two parts of salicylic acid to one hundred of neat's-foot oil and three of tincture of benzoin. The author has found benefit to result from repeated fly blisters. As long as any trace of the affection remains, recurrence of the bald patches is to be expected.

### Generalized Vaccinia in the Course of Dermatoses.

DR. LACOUR has been led, by the occurrence in his practice of a vaccinal eruption in an eczematous subject which occasioned death, to give his views upon the subject in the "*Lyon médical*" of August 18, 1889. In the case mentioned a child of eight months, who from birth had had an eczema of the face and scalp, was vaccinated upon the arm with virus from the calf. Upon the seventh day the skin was found hot and the child was petulant. Numerous pustules were present upon the upper part of the arm, the shoulder, and the

cervical region, and later spread to the face. Seven days later desiccation took place, but an obstinate diarrhoea persisted in spite of remedies, and it died about a fortnight later.

That the eruption was not variola appears from the circumstances that the child had not been exposed, and that during incubation there was no general disturbance. The pustules upon the shoulder and arm appeared at the same time as the pustules produced at the points of inoculation. Variola was not communicated to other children, and analogous cases are found in literature. Eight observations have been collected which establish fully the predisposition of those already subjects of dermatoses to a generalization of vaccinia. These are divided into two groups, the first formed by cases of auto-inoculation by transfer of the virus to regions affected by skin eruptions, the second comprising spontaneous vaccinal eruptions localizing themselves upon irritated parts which constitute a *locus minoris resistentiæ*, in which case it is a true eruptive fever.

Dauchez, in his thesis on this subject, relates thirty-one observations of generalized vaccinia. In five instances the subjects had an acute affection of the skin. In the nine observations given in this paper there were several which were accompanied by severe general disturbances, and two terminated fatally.

Auto-inoculations in subjects of skin affections may be prevented by the insertion of the virus as far as possible from the cutaneous surface which is affected, and applying an occlusive dressing; but a spontaneous generalization will not be hindered, as is shown by one of Besnier's cases.

#### **A Case of Localized Scleroderma combined with Hemiatrophy Facialis and Alopecia Areata.**

DR. O. ROSENTHAL, in the "Berliner klinische Wochenschrift" of August 26, 1889, relates the history of, and comments on, a case of localized scleroderma followed by hemiatrophy facialis and alopecia areata.

The patient, a girl aged seven years and a half, fell from a wagon when six months old. At the same time she had a furuncle on the left side of the neck, the scar of which is still visible.

Her present trouble dates from her fourth year and appeared without known cause. At that time the mother noticed white spots on the left side of the neck, and later such spots appeared on the scalp and face.

In the past summer spots of alopecia appeared on the scalp, and since the past winter an atrophy of the left half of the face has been plainly visible. On examination, the affection was seen to be limited to the left half of the head and neck.

A number of patches of scleroderma extend from the anterior border of the left sterno-cleido-mastoideus muscle to the middle line of the neck; they are slightly infiltrated and inelastic to the touch. Behind, at the border of the hair and on the face, patches of scleroderma are also present; the patches on the face are surrounded by brown spots resembling freckles. On the right side of the neck localized patches of scleroderma are also present.

The hairs of the left eyebrow have partially disappeared, and the cilia of the lower lid completely; over the left half of the head a number of bald spots are present, also several spots of pigmentless hair.

The skin of the left half of the face is shiny, not freely movable; its sensibility is preserved, as is also the secretion from the sweat and sebaceous glands. The author recalls a similar case presented by Dr. Gibney before the New York Dermatological Society in 1879, and published in the "Archives of Dermatology." In Dr. Gibney's case a girl aged nine years presented the same combination of symptoms, together with scleroderma in the region of the left sciatic nerve. As all of these diseases have been assigned to a tropho-neurotic disturbance, Dr. Rosenthal is disposed to look upon their association not as accidental, but as the result of a common cause.

### Infant Mortality from Syphilis.

DR. LE PILEUR, physician to the woman's prison, Saint-Lazare, in Paris, has recently published the results of a series of investigations made to determine the influence of syphilis upon infant mortality. There were 130 women concerning whom reliable information could be obtained. These fell into three groups: 1. Those who had acquired syphilis after having had children. 2. Those who had no children until after they had contracted syphilis. 3. Those who bore children both before and after they had become infected. The 78 women in the first and third groups had had altogether before becoming syphilitic 209 children. Of these, 8 were still-born (3·8 per cent.), 99 died shortly after birth (47·3 per cent.), and 102 lived (48·8 per cent.). The 70 women in the second and third groups bore 153 children after becoming infected. Of these, 120 were still-born (78·4 per cent.), 25 died soon after birth (16·3 per cent.), and but 8 survived (5·2 per cent.). The 18 women in the third group passed through 43 pregnancies before becoming syphilitic, with a result of 27 children who died shortly after birth, and 16 who survived. There were no still-births. These same women after acquiring syphilis presented a total of 31 pregnancies, which resulted in 21 abortions and 6 still-births; three children died soon after birth and but one survived. This last set of statistics would seem to show that syphilis exerts no special influence in preventing conception, but is extremely fatal to the foetus.

Basing his conclusions upon these and other studies, Dr. Le Pileur asserts that (1) of 100 pregnant women 14 are syphilitic; (2) of 100 children of syphilitic mothers not more than 7 will survive the first month of extra-uterine life; and (3), as a corollary of these two, 13 children out of every 100 perish as a direct consequence of syphilis in the mother.—*Bulletin de la soc. obstét. et gynécol.*, No. 11, 1888.

### A Contagious Eruption resembling Psoriasis.

DR. HANS BAAZ, of Gratz, writing in the "Berliner klinische Wochenschrift" of July 1, 1889, describes a peculiar affection which he observed in several members of the same family. He was called to see a little girl, four years old, who had been taken the day before with a fever. At the time he saw her the temperature was 101° F., pulse 112; the child seemed out of sorts and depressed, the tongue was coated, and the soft palate, uvula, and tonsils were very red and somewhat swollen. The ordinary remedies were given, and the following day the child was about well.

Five days after this the elder sister of this child consulted the writer on

account of an eruption which she had had for a couple of days. She stated that she had been somewhat indisposed and a little feverish just before the eruption made its appearance. On the inner side of both forearms, the left elbow, and the outer side of the arm were scattered a number of slightly elevated very red macules, from the size of a lentil to that of a *Kreuzer*, which were covered by quite a thick layer of white scales. On scratching away one of the scales, a minute drop of blood appeared. At first the eruption had itched a good deal, but now there was no discomfort from it, and it was chiefly because of its appearance that the patient was distressed. Dr. Baaz thought at first that he had to do with a psoriasis, and instituted treatment accordingly. The young lady told him that her little sister, whom he had first seen, also had an eruption, and upon examination he found similar roundish, red, and scaly patches on various parts of the face and arms. But these were not the only ones affected, and soon the brother of these patients, then their mother, and finally a young lady visitor from Marburg, were attacked with the same disease.

The eruption presented the same appearance and course in each case. First there was pretty smart itching, then red patches appeared in an otherwise normal-looking skin, and finally these became covered with glistening white scales. The spots increased in size on the periphery, the center becoming gradually smooth, and, except for a brownish-red discoloration, resuming the appearance of the normal integument. The eruption was confined in all the cases to the upper part of the body, and when located on the scalp it caused no falling of the hair. Under the use of chrysarobin ointment it disappeared in the course of six or eight weeks.

The writer's assumption that the disease was transmitted directly from one to the other was strengthened by the circumstance that two little boys, cousins of the first patients, who used to play with the little girl, were both attacked with the same disease. The mother stated that the affection was contracted in the first instance from a playmate of the little child first attacked, but the writer was unable to see that child in order to determine for himself the correctness of this statement.

Dr. Baaz confesses his inability to find a place for this disease among the recognized dermatoses. That it was not an acute exanthem was sufficiently proved by its long course. Eczema and lichen ruber were excluded by the form of the eruption, and a close examination showed that it could not be the so-called pityriasis rosea, herpes tonsurans maculosus, or pityriasis circinata, as it is variously designated. It resembled more closely than any other eruption psoriasis, but the very clearly contagious nature of the eruption argued against its being psoriasis. For the present, therefore, the writer would content himself with calling the disease an infectious psoriasis-like dermatosis, waiting until further study and more extended observation would permit of a more definite nomenclature.

### On the Absorbent Power of the Bladder.

TRICOMI, of Rome, has made a series of investigations on the absorbent power of the bladder for fluid and gaseous substances, for pathogenous micro-organisms and indifferent solid bodies, with the epithelium normal as well

as in a changed condition. The experiments were made on dogs, rabbits, and guinea-pigs.

From the results of these experiments the following conclusions were drawn :

1. The bladder has, in spite of the contrary assertion by some pathologists, a very great absorbent power. With intact epithelium this absorbent power is less for many substances than that of the surface of the skin.

2. In the conditions where the epithelium is not wounded the *Bacillus anthracis* and other microbes which may be kept in putrid fluid do not penetrate into the circulation. With an unwounded epithelium the *Staphylococcus pyogenes aureus* causes no changes.

3. With a changed epithelium, on the contrary, the absorption of fluids is decreased, while the penetration of pathogenetic micro-organisms into the blood-current is easily possible.

4. The *Staphylococcus pyogenes aureus* causes with changed epithelium acute purulent cystitis. If such a cystitis be present, the penetration of septic micro-organisms into the circulatory system is much easier.

D'Ambrosio, of Naples, observed that absorption takes place in the bladder even with changed epithelium. He mentioned the case of a man suffering from cystitis purulenta in whom injections of a solution of plumbic acetate caused symptoms of lead-poisoning. He also recalls two cases where, after washing out the bladder with a weak solution of carbolic acid, symptoms of poisoning appeared (Congress of Italian Surgeons in Bologna, "Wiener klin. Wochenschr.," 21, 1889).

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## Items.

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**Treatment of Pruritus and Irritable Skin.**—Norman Porritt, in the "British Medical Journal" for July 27, 1889, recommends the employment of a cone of cacao butter, impregnated with two per cent. of cocaine, in the treatment of pruritus and irritable skin. This is rubbed over the part affected. The warmth of the skin melts off a layer of cacao butter, which forms a soothing emollient shield over the irritable patch. The remedy has been put up in the form of cones, inclosed in boxwood cases with screw tops, something after the manner of menthol cones. In irritable affections of the skin, in cases of insect bite, in pruritus, and various other forms of hyperæsthesia, the remedy is worthy of a trial, and its use has a distinct advantage over the more usual applications. Although containing cocaine, the writer regards the manner in which the cacao butter is spread over the affected part as having a share in the curative process.

**On Hereditary Immunity from Syphilis.**—At the third general meeting of Russian medical men at St. Petersburg, Dr. Ivan A. Maieff read a very interesting paper on hereditary immunity from syphilis, in which he lays down the following propositions: 1. In an overwhelming majority of cases a single syphilitic infection makes the person proof against the virus—that is, protects him for life from a second contamination. 2. The immunity is transmitted from the subject to his offspring. 3. The hereditary immunity may be transmitted even to a third generation (to grandchildren). 4. In some

cases the inherited immunity constitutes the only evidence of parental syphilis. 5. The hereditary immunity varies considerably in its intensity; sometimes it is absolute—that is, lasts during the person's whole life—while in other cases it is only of a more or less temporary character. 6. In cases in the latter category—that is, in cases in which an inherited immunity gradually becomes exhausted—a subsequent infection assumes a peculiar form of the so-called abortive syphilis.—*Medical and Surgical Reporter*, August 17, 1889.

**Prophylactic Hair-wash.**—The following hair-wash, given in the “*Therapeutische Monatsheft*” for July, 1889, is said to keep the scalp cool and the hair dry and free from oil, also to prevent dandruff, besides being a most agreeable toilet preparation:

R Spirit of ether.....	f 3 jss.
Tincture of benzoin.....	f 3 jss.—f 3 ij
Vaniline.....	℥ j
Heliotropine.....	℥ iiij
Geranium oil.....	gtt. j

M. Sig.: For hair-wash. Keep well corked and do not expose to flame, as the mixture is highly inflammable.—*Medical News*, August 31, 1889.

**Treatment of Baldness.**—Dr. E. Besnier states that the falling out of the hair may be checked and a new growth started by the following treatment. The hair should be cut short and a mild sinapism or rubefacient applied to the scalp; then every five days the following lotion is to be applied:

R Acid. acetic,	
Chloroformi.....	āā q. s. M.

The above should be used cautiously, as it is an irritant, and stimulates the hair powerfully. In connection with the above, the following pomade should be used:

R Acid. salicylic.....	gr. xv
Sulph. precip.....	3 jss.
Vaseline.....	3 v. M.

This pomade should be applied fresh every morning, the scalp having been previously washed. Fatty substances retard the growth of the hair and should not be used.—*Jour. de méd. de Paris*; *British Journal of Dermatology*, September, 1889.

**Practical Method of mixing Vaseline and Water.**—Krebo (“*Mal. cut. et syph.*,” No. 2, 1889) has found that the addition of a few drops of castor-oil to pomades containing vaseline and aqueous liquids effects their amalgamation. Two drops of the oil to a gramme of the liquid to be mixed with the vaseline are sufficient to make a fine emulsion.

**An Excipient for Local Applications in Dermatology.**—M. Vergely has recommended a modification of the local applications of Unna. The preparations of the latter are sometimes difficult to make, and have a granular consistency. M. Vergely avoids this difficulty and obtains a more perfect homogeneity in the following formula:

R Gelatin.....	5.0
Glycerinae,	
Aque.....	āā 45.0

This mixture is flexible, adheres to the skin, and is useful as a vehicle for powders, as calomel, oxide of zinc, red precipitate, etc.



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## Original Communications.

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### AN UNUSUAL FORM OF PUSTULO-ULCERATIVE DISEASE OF THE SKIN.\*

By E. B. BRONSON, M. D.,  
Physician to Charity Hospital.

**T**HE following remarkable case of cutaneous disease was observed during the past summer at Charity Hospital, New York :

The patient was a boy, fourteen years of age. He was admitted on July 5th, and I first saw him three or four days later. The most striking thing about the patient's appearance at first glance, was a markedly swollen condition of the face, accompanied with an eruption, the nature of which was not easily determined. The swelling, though general, affected chiefly the forehead, eyes, and mouth. The forehead was bulging and pitted on pressure, and on either side was a confluent exanthem, covered with thin, adherent, blackish scales or scabs. The eyelids, especially the lower, were so swollen and puffy that the palpebral apertures were reduced to narrow slits, through which it was difficult for the patient to see. The lips also were thickened and protuberant. Scattered over the face were papules and tubercles, pustules and incruusted ulcerations, together with a multitude of rounded or irregularly shaped cicatrices, slightly depressed below the *niveau*, and varying in size from that of a pin's head to that of a lentil. Many of the larger scars were studded with minute pits, such as are observed in vaccination marks. The efflorescences were mostly arranged in groups. The papules were red, with little or no areola, many of them showing pus at the summit. The larger ones, or tubercles (some of them as large as a pea), were colorless, and seemed to contain pus. The scabbed lesions on the forehead were found, on removing the black crusts, to be superficial ulcerations, of a bright-red color, easily bleeding, and secreting but little pus. There were no comedones noticeable ;

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\* Read before the American Dermatological Association, in Boston, September 19, 1889.

the scalp was unaffected ; the cervical glands were but little enlarged. On being stripped, the patient was seen to be well formed—perhaps a little undersized, and, while not of robust appearance, not emaciated. Scattered over the trunk and extremities were lesions similar to those upon the face, without the oedematous infiltration. Everywhere was seen the same tendency to corym-



biform arrangement. Between the groups the skin was for the most part normal, with here and there an isolated papule or tubercle. Upon the body the lesions could be better studied than upon the face, owing, probably, to a more undisturbed development. The regions most markedly affected were the nates and the scapular regions of the back. On the right side the disease

seemed generally worse than on the left ; the lesions on the right were both more numerous and more severe. They were severest upon the nates. In this situation, especially over the tuberosities, were a number of deep ulcers of irregularly rounded outline, with sharp-cut, not undermined edges, deep-red or slightly grayish base, and varying in size from a few lines to half an inch in diameter. From some of these an abundant amount of pus could be expelled by firm pressure of the base, apparently welling up from subcutaneous cavities. Besides the ulcers, in this situation were several tubercular elevations, some purplish, others uncolored. Everywhere were cicatrices like those upon the face. There were numerous pigment spots over the body, and, over the scapulae, where the papules and pustules were very abundant, the surface was thickly studded with petechiae. Under and to the forward part of the right axilla were numerous similar petechial stains, closely packed in an elongated group, an inch long. The front of the trunk was less affected than the back, though there were several isolated and grouped papular or pustular efflorescences also here. The extremities were affected, especially on the extensor surfaces of the arms (the elbows more particularly), the knees, and both thighs and legs. On the elbows and knees were ulcers similar to those on the forehead. The hands and feet were for the most part free. So far as could be determined from the freshest efflorescences, the primary lesion consisted of a little red papule, pustule, or in some cases vesicle, occupying the site of a hair follicle, in each instance the lesion being perforated by a hair. Such hairless parts as the palms, soles, and flexures of the joints were entirely unaffected. In its further development the efflorescence might either undergo resolution, leaving a fine lichen-like papule, with a little crust on the summit, or the inflammation extended, the lesion often becoming violaceous in hue, and a large tubercle, pustule, dermic abscess, or ulcer resulted.\*

The history given by the patient, who was uncommonly dull-witted and slow of comprehension, was meager and unsatisfactory. His mother and an aunt had probably died of phthisis. He had been well up to a year and a half ago, when a "sore spot" came on the right side of the forehead, that was very slow in healing. He attributed it to something that had poisoned him while bathing in a canal near swamps. At about this time an abscess was opened in the neck. Shortly after this he became an employee in a manufactory of paper hangings, where he remained for about a year. After commencing this occupation the sore became worse, was raw, and discharging. At a dispensary he received treatment which gradually healed it. Shortly afterward, however, it broke out again, and a general eruption appeared over the body. The skin affection gradually grew worse, but not till a month or so previous to his entrance at the hospital was it so bad as to make him give up his occupation. At this time the face, though for a long time previously somewhat swollen, became much more so, and, the trouble continuing to grow worse, finally his father secured his admission to Charity. While he has been suffering from this eruption he is not aware that his general health has

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\* The accompanying plates are from photographs taken shortly after the patient entered the hospital.

been much affected. His appetite has been good, and the cutaneous disease has not been attended with much discomfort, either from itching or pain.

During his stay in the hospital no especial constitutional disturbance was noted, excepting for a few days during which there was some fever, with furred tongue, malaise, inappetence, and an evening temperature of 101° F., with morning remission. The urine was carefully examined, with negative result. Under tonic and antistrumous remedies the skin disease was gradually ameliorated, and at the end of two months, when the father came to take the patient away, the ulcers had all healed (though they had been very slow in healing for the first few weeks), the swelling of the face was much reduced, and the eruption of pustules had almost ceased. During the greater part of his stay in the hospital, however, successive crops, usually in groups, continued to appear.

After his discharge from Charity I lost sight of the patient till within a few days, when, after some difficulty, I succeeded in tracing him to St. Francis's Hospital, in Jersey City. There, through the courtesy of Dr. Watson, the attending physician, I was enabled to make another examination. I found the patient in considerably worse strait than when I saw him last. The face was more swollen than I had ever seen it. The eyelids were enormously swollen and bluish, and the skin of the forehead was so cedematous as to form a fold just above the eyebrows. The ulcers on the forehead looked much as they had when he entered Charity, but were more numerous and extensive. They were covered by thin, black, tenacious crusts, the same in appearance as before. The crusts being torn off from part of the ulcerated surface, there was free bleeding, but no pus could be made to exude by pressure. The lips were thick and protuberant, and also the cheeks were considerably swollen. To the right side of the mouth there was a hardish nodule, the size of a bean, while overlying it was an oblong, dark, thin crust (like those on the forehead), half an inch long, covering a superficial ulceration. One side of the neck was much swollen, and here could be felt a bunch of swollen lymphatic glands. On the back of the neck was an oval, elevated patch, two inches long, covered with the thin, black, tenacious crusts, and also looking like the patches on the forehead. On the buttocks were numerous thin, slightly depressed cicatrices, some as large as beans, but no fresh ulceration. On the body and extremities there were some papules, pustules, and tubercles, but not very numerous. There were many pigment stains and some petechial spots. Many of the papules were ecchymotic. On the upper part of the chest and near the shoulder there was a cluster of papules, crossing which were a number of elongated ecchymoses, or vibices. The patient's general condition appeared to be poor. He seemed somewhat feeble. The appetite continued fair, but the tongue looked furred and flabby. At the time of the examination there was apparently no fever, and none had been observed by his attendants since his entrance to the hospital.

As to the nature of this somewhat anomalous malady, it is plain that such cutaneous lesions could hardly occur independently of some depraved state of the general system. Their long persistence and disposition to relapse, the pyogenic tendency, and the occurrence of ecchymoses, are all



significant of a condition of cachexia. Again, the evident implication of the sebaceous follicles, at least in the primary efflorescences, would stamp the disease as essentially or primarily an acne (if that term be admissible, in its broader sense, for inflammations of the sebaceous follicles generally, whether accompanied with steatosis or not). Hence it would seem that, from among the recognized forms of skin disease, the one known as "acne cachecticorum" most nearly expresses the clinical character of the above case, though modified in a peculiar way. What was accountable for the modifications of the eruption in this case, though an interesting question, is one not very easy to answer.

At first it was thought that there might be some connection between the disease and the patient's previous occupation in the paper-factory, on the supposition that there might have been exposure to arsenic. It is well known that arsenical poisoning may not only produce pustular lesions upon the skin, but deep-seated suppuration and boring ulcers. This theory was abandoned, however, for two reasons: First, because of the long persistence of the disease, and even its aggravation long after the patient's removal from all possible exposure to arsenic. Some time after the patient's admission to Charity Hospital, and when the lesions had begun to improve, arsenic was administered tentatively, in the form of Fowler's solution, though in small doses, and continued for about a week. If any effect was produced, it was to promote the improvement. Moreover, after some careful inquiries at the establishment where the patient had been employed, as well as at some others of the same class, there seemed good reason to believe that at the present time arsenic is not used in these establishments in coloring papers. It is only in the more brilliant colors, such as are not now in vogue for paper-hangings, that arsenic is employed. Formerly, I was informed, when brighter colors were used, the workmen not infrequently suffered from pustular eruptions, especially upon the hands and arms, and often also about the genitals, but such affections, I am credibly informed, are now never seen. While it is possible that traces of arsenic may occur in the materials used, it is extremely improbable that this could account for such an aggravated form of disease as the one which has been described.

That struma may have played an important part in the disease, either as a modifying or predisposing factor, is not improbable, though among the lesions no forms were observed that could be characterized strictly as scrofulodermata. No disposition to cheesy degeneration of the glands, none of the violaceous tubercles that break in the center, discharging sanious pus, and followed by spreading ulcers, with thin undermined edges, were observed, nor was there anything that could be clearly recognized as a scrofulous lichen. Nevertheless, the marked pyogenic tendency, the indisposition to repair, together with certain indications in the family his-

tory, besides the difficulty of in any other way accounting for the patient's cachectic condition, pointed rather directly to a strumous habit.

The supposition of a syphilitic taint seemed scarcely worthy of consideration. There were no such infiltrations as would be characteristic of syphilis. The lesions were purely irritative and of simple inflammatory character. There was, moreover, in the ulcerations no serpiginous or other modes of extension characteristic of syphilis.

The œdematous infiltration of the face is not easily accounted for. The blood dyscrasia may have had something to do with it, which also was accountable for the ecchymoses; but it seems more reasonable to attribute it to some more local difficulty. It is possible that confined pus, in the deeper tissues of the skin, may have been the cause of it, though none such was discovered.

A word with regard to the arrangement and distribution of the efflorescences. In their corymbiform or herpetic arrangement, and in their tendency to occur in successive crops, an analogy is suggested with the dermatitis herpetiformis of Duhring, and it is not improbable that the same neuropathic cause which is involved in the latter disease was also present in the case above described. Indeed, it is reasonable to suppose that this neuropathic factor is common to many diseases that occur in a similar form. In this case the eruption was primarily superficial and of a simple character. It appeared to be essentially seated in the epidermic layer, but, through aggravation of the inflammatory process, and through the feeble power of resistance in the surrounding tissues, the process rapidly invaded the deeper structures. A similar extension of inflammation beyond its original limit is often observed in zoster, where an originally superficial catarrhal disease becomes an ulcerative or gangrenous affection, and likewise in cethyma. Hence, while the above case may be characterized as primarily an *acne*—an *acne cachecticorum*—through modifying circumstances it became an *acne cachecticorum phlegmonosa et ulcerosa*.

123 WEST THIRTY-FOURTH STREET.

NOTE.—A subsequent examination of the patient was made on October 16th. A very marked improvement was noted both in the patient's general condition and in the skin. The ulcerations had healed, the swelling of the face, though not entirely gone, was greatly diminished, and the only remaining signs of the disease, besides the multitude of cicatrices and pigment-stains, were a very few brownish-red, indolent-looking miliary and lenticular papules. There was in all scarcely a dozen of them, mostly occurring upon the extremities, either isolated or in groups. A few of them showed some indications of pustulation. The treatment had been tonic and antistrumous.—E. B. B.

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## ON THE OCCURRENCE OF PRURIGO IN AMERICA.\*

By JOSEPH ZEISLER, M. D.,

Member of the American Dermatological Association; Professor of Dermatology in the Woman's Medical College and the Post-graduate Medical School, Chicago.

IN the following paper I have endeavored to determine whether true prurigo really exists in this country; and if it does, what its relative frequency is, and, if a considerable difference should be noted in its proportion to the number observed in other countries, what the probable causes might be for such a difference.

Although Willan had unmistakably described prurigo years ago, comprising, however, conditions under this head which—like prurigo senilis and localis—are not to-day regarded as the same disease, and in spite of the classical, exhaustive description by Hebra, which ought to make the diagnosis of typical cases of prurigo a mere bagatelle, it has taken years, strange as it may seem, before that disease has been universally recognized in countries outside of Austria, and perhaps Germany. In France, for instance, the disease was only up to ten years ago nearly unknown—that is, it was not recognized—when Kaposi, who, during a visit in Paris, was present at some of the clinics, easily picked out among the ambulants quite a number of genuine cases of prurigo. Since then the existence of this disease in France has been freely admitted.

At the fifth International Congress at Philadelphia in 1876, J. C. White, speaking on the differences in form and occurrence of skin diseases in this country, declared that prurigo (as well as lichen ruber, pellagra, and others) did not exist in America.

Again, at the seventh International Congress in London in 1881 it happened that an animated discussion took place whether prurigo really occurred in England, for the senior of English dermatology, Wilson, and a host of others, had always protested that it did not exist there. But the demonstration of a number of cases by Morratt Baker, which Kaposi himself diagnosticated as true prurigo, has since settled the question. Baker explained that the frequent complication by eczema had caused the error, and that prurigo was not at all rare in England, and Liveing and Walter Smith, of Dublin, fully concurred in this view; and to-day McCall Anderson writes: "My own experience, however, would lead me to conclude that, in this country at least, it is not so rare as is generally supposed, and is often mistaken for other affections." On the other hand, it must be wondered at that only two years ago another English writer, Tom. Robinson, could have the remarkable boldness to formulate conclusions like these: "There is no such disease as prurigo"; "all the groups of symptoms which

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\* Read before the American Dermatological Association, at Boston, Sept. 17, 1889.



are known as prurigo are the result of scratching and are simply symptoms"; "the pruriginous skin of children has its origin in developing hair-follicles, which progress *from birth to puberty* [*Italics mine*], when it stops," etc.

Such enunciations can hardly be taken seriously, for whoever may read Robinson's paper can readily see that the cases upon which he bases his conclusions show most divergent pictures and have nothing to do with prurigo, and that he ignores entirely one of the most prominent features of it—the chronicity of true prurigo, lasting far beyond puberty.

In this country, however, the last decennium has brought a very radical change; and at least among those who devote their especial attention to the study of dermatology there seems to be an almost unanimous consensus of opinion to the effect that true prurigo undoubtedly exists here, but the graver form is rather rare. Out of the large number of observers I shall cite a few only.

Hyde writes: "While the typical prurigo ferox, as described by the Vienna school of authors, is of such rarity that probably less than a dozen cases have been observed in this country, the opinion is gaining ground that the same disease, with milder manifestations (prurigo mitis), is much more common here than has at times been believed."

Morison is a little more reserved. He says: "Foreign dermatologists are incorrect in suggesting that the disease is overlooked in this country. The fact is, it hardly exists here, and if seen, most often in those who have come into the country from abroad, bringing it along."

Duhring says the disease is extremely rare and almost unknown in the United States.

Fox again, in a discussion on prurigo at the New York Dermatological Society, declared that "prurigo is not such an uncommon disease in this country in its mild form."

The same view is held by Bulkley, who writes: "The severe form is very rare here; in a milder form it is not infrequently met with in the poor."

Coming from a school of dermatology where prurigo is so common that Duhring, for instance, calls it the home of the disease, and being therefore fully acquainted with its picture, it was of especial interest to me to study the mooted question in this country. It will hardly be necessary for me to recall before this learned body the characteristics of prurigo, or to use any arguments in favor of its clinical entity. Nor will it be essential for the purpose of this paper to discuss some recent divergent opinions as regards the pathological nature of the prurigo nodule; for while Auspitz, Hebra, Jr., Riehl, Schwimmer, and others may differ from the older Hebra and among each other regarding the pathology and ætiology, none of them have denied that, in a clinical sense, prurigo is a dermatosis *sui generis*.

My own observations during the last five years in Chicago have demonstrated to my mind beyond any doubt that true prurigo—the so-called prurigo agria—does unquestionably occur here, although, as I may say right here, in a much smaller proportion than in Vienna.

Of 1,370 cases of skin diseases observed during the period mentioned, only 12 cases of prurigo were noted, 5 of which might be classed as severe, while the rest, although still typical, were milder forms. Of these 1,370 cases, 1,108 were met in private practice, with 9 cases of prurigo (3 of prurigo agria and 6 of prurigo mitis), which would give a percentage of 0·812, while the 3 cases seen among 262 dispensary patients during the last year would make 1·145 per cent. Taking the whole number, the percentage is 0·875. This shows a considerably larger proportion than the returns of the American Dermatological Association. This body reports for the years 1878 to 1887 34 cases of prurigo out of 123,746 cases of different skin diseases—equal to 0·027 per cent.; and during the last year (1887-'88) 5 cases of prurigo out of 15,165, or 0·033 per cent. Morrison mentions the statistics of the same corporation for three years with 13 to 38,320, or again 0·033 per cent. Of the statistics of foreign countries I could find, unfortunately, none which were based upon nearly as large numbers as those of our association.

Lazansky reports from Pick's clinic in Prague for the year 1874 3 cases of prurigo out of 530 skin patients, a percentage of 0·566.

Theod. Veiel reports for the year 1875 3 to 175, or 1·714 per cent. Hiorth, in Christiania, during the 15 years 1873-'87, 54 cases out of 1,594 patients, or 3·387 per cent. O. Simon says that severe forms of prurigo are not at all rare in Berlin and Breslau, and form two to three per cent. of all skin diseases there. Of the Vienna hospital I was unable to find an exact statistical report.

My own twelve cases are appended in tabulated form. While the five severe cases left no particle of doubt as regards the diagnosis, showing the typical localization, distinct prurigo papules at some time or another, glandular swelling in the inguinal region, hypertrophy and pigmentation of the skin over the affected area, pale color of the face, history of early inception, frequent relapses, etc., I felt justified in making the diagnosis in the remaining seven cases, designated as mild, when at least a number of those symptoms were present, sufficient to produce the characteristic picture. My list shows, however, the singular fact that, of those twelve cases, only one was born of American parents, while eleven were either of foreign birth—namely, four, comprising two severe cases—or were born here from German parents. This may be due to some extent to the fact that my practice in general shows a considerable proportion of German patients, and that Chicago's population is strongly cosmopolitan in character. As regards the sex, seven were males and five females, corresponding with the experi-

## PRIVATE PATIENTS.

No.	Name.	Age.	Sex.	Date of first observation.	Nationality.	Place of birth.	Time of sojourn in this country.	Duration of the disease.	Character of the disease.	Complications.	Circumstances of patient.	Remarks.
1	S. Bl.	32 y.	M	Aug., '84.	German.	Austria.	18 yrs.	Since childhood.	Mild.	.....	Good.	Otherwise healthy; cured by several months' treatment.
2	Al. R.	7 y.	M	Dec., '84.	Parents German.	Chicago.	Always.	5 yrs.	Very severe.	Eczema.	Very good.	Has been treated during the summer by Prof. Neumann in Vienna; improves readily upon treatment; frequent relapses during the following years.
3	W. Gr.	3 y.	M	Feb., '85.	Parents German-American.	Chicago.	Always.	2 yrs.	Mild.	Frequent urticaria, mild eczema.	Very good.	Cured.
4	H. Abr.	20 y.	F.	Feb., '85.	German-American.	Illinois.	Always.	Since childhood.	Severe.	Eczema.	Poor.	Distinct pruritic papules; pigmentations; glandular swelling; improves readily; frequent relapses during four years of observation; very typical case.
5	M. M.	3 y.	M	Aug., '85.	German-American.	Chicago.	Always.	2 yrs.	Mild, but typical.	.....	Poor.	Cured.
6	Elsa W.	3 y.	F.	Feb., '86.	German-American.	Chicago.	Always.	1 yr.	Mild.	.....	Good.	Cured.
7	M. B.	22 y.	F.	Feb., '88.	German.	Germany.	A few years.	Since childhood.	Mild.	.....	Poor.	Cured.
8	F. R.	13 y.	M	Dec., '88.	German-American.	Chicago.	Always.	11 yrs.	Very severe.	Artificial eczema.	Poor.	Distinct inguinal buboes; slight swelling of cervical glands; flexor surfaces over joints perfectly free; increasing intensity from upper arms to lower limbs; distinct pruritic papules; improves upon treatment, but relapses soon again.
9	L. N.	3 y.	F.	Jan., '89.	German.	Chicago.	Always.	2 yrs.	Mild, but typical.	Frequent urticaria.	Fair.	Glandular swelling; distinct pruritic papules; improved, but not cured at time of writing.

## DISPENSARY CASES.

10	I. M.	12 y.	M	Oct., '88.	German.	Austria.	7 yrs.	10 yrs.	Very severe.	Eczema.	Poor.	Very typical case.
11	N. B.	25 y.	M	June, '89.	German.	Germany.	4 yrs.	24 yrs.	Severe.	.....	Poor.	Very typical.
12	S. B.	16 mos.	F.	July, '89.	American.	Chicago.	Always.	8 mos.	Mild, but typical.	.....	Poor.	

ence of most observers. Concerning the circumstances of those patients, I have classed seven as poor, by which I at least meant that the regular use of a bath-room, and proper care as regards general health, was not afforded. Four of these seven cases were affected by the severe form. Of the five patients who lived in comfortable circumstances, only one had prurigo agria. The experience thus gained is in harmony with that of most American writers. That a sojourn of several years in this country had in itself a mitigating influence upon the disease does not follow from my notes. As regards the result of treatment, five of the seven mild cases have been cured; the two others are improved, but have not been long enough under observation to form a definite opinion. Of the five severe cases, four, who have now been watched for longer periods, seem to prove the truth of Hebra's sad verdict—they improved often readily, but the least neglect in the care of their skin brought on a relapse.

The fact that a disease like prurigo should be so very common in central Europe and comparatively rare in the United States has in itself nothing surprising. Geographical influences have surely something to do with the distribution of certain diseases. The most striking example in this respect is, perhaps, furnished by lupus, which is so frequently seen in Austria and Germany, and which, as far as I could learn, is extremely unusual in this country; and yet lupus is now almost universally regarded as one of the forms of (local) tuberculosis, a disease, as far as it affects the respiratory organs, at least, about as common here as in Europe. A similar contradiction may be noticed concerning prurigo, of which all observers state that it makes its first appearance under the picture of urticaria. Now, urticaria is surely not a rare malady among small children, and still is followed so rarely by true prurigo. I am at a loss to give an explanation for this apparent contradiction.

One of the most plausible causes for the relative rarity of prurigo here seems to me to lie in the fact that even the poorer classes are here still far better off than in Europe, and that bath-rooms are with us a privilege of a large majority of all classes, while there they are a luxury which only really rich people enjoy; and since frequent bathing is one of the most powerful remedial agents for a beginning prurigo, and since all writers claim that it is mostly found among lower and ill-fed people, the above-mentioned influence will be easily understood.

I have sought for an explanation why my own statistics, although based upon a small number, should be in such a striking contrast to that of the American Dermatological Association, which reports relatively only a thirtieth of the number seen by me. I have no right to doubt the diagnosis of others, but perhaps some of the American observers have been somewhat too scrupulous in applying the term prurigo to such cases only as are absolutely typical. The frequent complication by eczema and inter-

current urticaria eruptions may often disturb the clinical appearance, and thus make the diagnosis doubtful, but a long-continued observation will reveal, at some time or another, the characteristic papules on the favored localities, or other distinct symptoms of the disease. A little liberality in this respect will, perhaps, in the future place under the title of prurigo what has heretofore been classed as eczema, urticaria, lichen urticatus or pilaris, pruritus, etc. However that be, the following conclusions will hardly be disputed :

1. Prurigo does surely exist in America.
2. The severe form, prurigo ferox s. agria, while occurring in perfectly typical examples, and on patients born and raised here, is of comparative rarity, and is often only imported.
3. Prurigo mitis is not uncommon here.

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## NOTES ON A CASE OF MACULÆ CÆRULEÆ.

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**M**ACULÆ cæruleæ, *tâches bleues*, *tâches ombrées* or *ardoisées*, have been known to clinicians long ago. Our knowledge in regard to this peculiar exanthem of "blue spots" is, however, still at present extremely limited, and the real nature of the process is by no means clear. Piédaquel, Forget, Davasse, Moneret, Béhier, Jacquod, Troussseau, Lewin, Griesinger, and others who wrote about this subject traced the eruption to a variety of diseases of the general system as causes, but finally reached the conclusion that the "blue spots" were merely accidental, and that no diagnostic or prognostic importance ought to be attached to them.

The connection between maculæ cæruleæ and the presence of pediculi pubis was discovered in 1868 by pupils of Dr. Falot, of the Naval School of Toulon. Gestin ("École de Brest," 1878), Mourson, and O. Simon ascertained beyond doubt the phthiriasic nature of the eruption by reporting their careful clinical observations. Duguet in 1880 succeeded in producing maculæ cæruleæ by pricking the skin with a lancet-point charged with a paste made by rubbing up the bodies of twenty-five lice. This inoculation proved successful, however, only in persons who had the eruption before the inoculation. According to Mallet, the "*materia peccans*" comes from the two pairs of salivary glands contained in the thorax of the crab louse opposite the anterior pair of legs.

The following is a case of maculæ cæruleæ which lately came under my observation.\*

Fred. W. H., aged twenty-two, American by birth, was sent to me through the kindness of Dr. F. Tilden Brown, who was treating him for a gonorrhœal epididymitis. The patient stated that he has always been healthy and was never before troubled by any skin disease. Three days ago he noticed a faint eruption on his legs and body. He has blonde hair and a very light skin. The eruption consists of macules of the size of a lentil to a finger-nail, or even a little larger. Some have a round, others an irregular oval shape. Gyrate figures can be seen on some places as a consequence of the confluence of densely grouped individual spots. The eruption is localized on the inner surface of both thighs, reaching downward till to the middle of the femur, and bordered outward by a line approximately corresponding to the sartorius muscle. There are quite a number of spots on the anterior part of the abdomen and a few on the sternal region of the breast. The most interesting point of the eruption is its peculiar color. The spots are of a decidedly bluish hue, steel-gray, with a slight tendency toward sepia-brown. I have always

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\* The case was shown to the Society of German Physicians, and also seen by Dr. Bulkley, Dr. Fox, and Dr. Jackson.

looked upon color in skin diseases more from an artistic than anatomical standpoint, and found that there are three degrees of depth, if I may say so. There are superficial or covering colors (pityriasis versicolor), intermediate or penetrating colors (purpura hæmorrhagica), and deep colors (roseola), which in reality are only effects of color—*i. e.*, colors produced by the combination of differently colored layers, one of which is more or less transparent. There is no doubt that the color of *maculæ cæruleæ* belongs to the last category.

After the patient has been stripped and exposed for a while to cool air the color of the spots becomes more marked. Seen by oblique light and from a distance, the spots look slightly depressed in the center, but, in my opinion, there exists absolutely no alteration of *niveau*. On pressing on the macules with the finger they do not disappear, but assume momentarily a more yellowish hue. A great number of pediculi pubis are present in the hair of the genitals, of the legs, of the median line of the abdomen, and of the breast around the nipples. The itching caused by the pediculi is very moderate. The patient states that slight rubbing is sufficient to alleviate it, and this assertion is borne out by the conspicuous absence of scratch-marks and any other symptoms of irritation. Blue ointment was ordered to be rubbed in morning and night. I may condense my further notes on this case by saying that the macules gradually disappeared with the removal of the parasites in about twelve days.

That the eruption does not consist of mere stains of the epidermis is evident from the above description. That there is no hæmorrhage or true pigmentation has been proved by careful microscopical examination. There remains now only the supposition that it is a hyperæmia. I am inclined to look upon it as such in spite of some peculiarities which are uncommon to this pathological condition. Hyperæmic spots disappear on pressure, it is true, but I think that in exceptional cases, where there is an epidermis of extraordinary transparency, this rule may not hold good, and a change of color may be unnoticeable. Dark-red spots seen through a semi-transparent, yellowish layer of some thickness will assume the peculiar bluish color which is the most characteristic symptom of *maculæ cæruleæ*. I should be very glad if men of more experience and better facilities than myself would pay attention to this peculiar eruption, and confirm, if possible, my view about it.

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## THE HYGIENE OF THE SKIN IN HEALTH AND DISEASE.

By JOHN V. SHOEMAKER, A. M., M. D.,  
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*(Concluded from page 380.)*

“CLEANLINESS is next to godliness.” Frequent ablutions are necessary to the health and beauty of the skin. Dirt accumulates constantly upon the surface of the cuticle and interferes with all the functions of the integument. Those organic and inorganic materials, if undisturbed, form an overlying pellicle which limits the depurative functions, and consequently tends to exert a prejudicial influence upon the health of the system at large as well as that of the skin. The epithelial cells, too, become agglutinated. Furthermore, this layer is frequently, if not always, impregnated with pathogenic microbes which may readily obtain entrance into the blood. The incrustation of dirt and cuticle can not be removed by water alone, but requires the agency of soap. The epithelial cells, also, are soluble in soap and water. Sebum is a fatty substance, and may be removed by the same means when, as is often the case, it becomes inspissated, and plugs up the little ducts in which it is contained. The interference with function, the absorption of moisture, the decomposition of the constituents of the dirt and of the perspiration, cause local inflammation, as intertrigo and eczema, besides favoring the development of animal and vegetable parasites, especially the latter. But water fulfills other purposes than that of cleanliness. It is also capable of stimulating the nervous influence and circulation of the skin, and, through these, may exert a powerful influence upon the whole system. It may be used at different degrees of temperature, of alternating temperatures, or in the form of vapor, and may be impregnated with various drugs. Again, the effects may be modified according as the bath is general or local. In a vigorous person the shock of a cold shower-bath or douche is presently succeeded by a delightful glow. This mode of application, however, is inadmissible for an invalid. The Russian and the Turkish baths powerfully and, as a rule, beneficially affect the whole system. They cleanse the integument and promote its vigor. Surf-bathing is usually tonic in its effects, although weakly individuals or those unaccustomed to sea-bathing may not derive any advantage from it, either on account of failure of reaction or from remaining in the water too long at a time.

Toilet paints and powders are mentioned only to be condemned. The former, especially, must be injurious since they are, for the most part, composed of red lead or mercury and must irritate and roughen the cuticle at least. Frequently they cause actual inflammation in the parts to which they are applied. It is well known that actors and actresses often suffer



in this way. A bland powder may not be objectionable, dusted lightly over the face of those who have oily skins, but it should be used sparingly. In pathological conditions powders are often very useful. The remarks which I have made concerning paints apply, in the main, to the use of lotions or washes used with the view of beautifying the skin or repairing the ravages of time.

Climate has an undoubted effect upon the well-being of the skin. The customary temperature of the atmosphere and its condition as respects the degree of moisture, joined with the modifications of dress, diet, and general habits of life which it creates, establish a predisposition to certain forms of disease. Thus we are informed that in the East Indies and China scarcely one person in ten is free from some variety of skin disease. Certain diseases are distinctive of certain regions of the globe. Ainhum and Delhi boil, for instance, prevail in the tropics, verrugas in Peru, and pellagra in northern Spain and Italy. The skin certainly requires somewhat different treatment, both in health and disease, according to whether the climate be cold and dry or moist and warm. In the former case, fatty articles of food and the local use of unguents are demanded; in the latter, the moisture of the air, in addition to frequent ablutions, together with a diet largely farinaceous, are the best general hygienic and preventive measures at our command.

The hairy scalp calls for particular attention. The general nutrition of the individual, if defective, should be amended. The constant use of stiff, tightly fitting hats is a frequent cause of premature baldness. The hair is the natural protective or clothing of the head, and the conventionality which compels head-wear is responsible for the prevalent baldness of civilized races. In winter men should wear soft hats pierced with numerous holes in order to permit of ventilation; in summer, light straw hats of open structure. The head-gear of women usually has the advantage of being lighter than that worn by men, but, on the other hand, the use of false hair, switches, etc., exerts an injurious influence upon the scalp and hair. The scalp should be washed with soap and water once, or perhaps twice, a week. The best kind of soap to use for this purpose is a pure white soap. Ladies, after washing the hair, should allow it to dry thoroughly before having it dressed. After cleansing the hair and scalp the local application of oil is advantageous, preferably one of the animal oils. It renders the hair glossy. The oil of ergot is particularly to be recommended. Pomatum is objectionable because so frequently adulterated, and its decomposition proves irritant. The coarse comb should be elastic and its teeth large and blunt-pointed. The fine comb is useful in removing dirt and dandruff which adhere to the scalp, but no good is derived from employing it so roughly as to scratch the scalp. The hair should be gently brushed several times a day. The best bristles are of whalebone. Wire

bristles are irritant and often cause the hair to fall out. Contrary to the general belief, frequent cutting or clipping of the hair does not increase but restrains its growth, and in time actually leads to its loss. These facts have been scientifically determined by Kaposi and Pincus. Most hair-dyes are decidedly deleterious; none is to be commended. Inflammation of the scalp at times results from their use. Another class of agents—more used formerly than now—known as depilatories, aim at the removal of superfluous hairs. Inasmuch, however, as, to accomplish their object, they must destroy the hair-follicle, they are likely to do more harm than good by causing inflammation of the skin. They are now being superseded by electrolysis, which is in every way a preferable procedure.

Among the rudest races of the tropics, modesty, decency, or custom ordains that the sexual organs should be swathed. Other need of clothing those peoples have none. The case is far different in more rigorous climes. Comfort, or even life, demands the use of clothing. The semi-civilized inhabitants of hot countries make great use of cotton and linen fabrics. These, however, in colder regions, as in northern Europe and America, are sufficient only for underwear. Cotton is preferable to linen for use in hot climates, since it does not absorb so much moisture. The perspiration which linen absorbs remains in its meshes, gradually evaporating and abstracting heat from the body until it causes chilly sensations. In cold climates or seasons most clothing is made of wool, a bad conductor and good radiator of heat. Of course, the clothing can not generate heat, but can only restrain the dispersion of that generated within the body. The little atmospheres contained within the meshes and between the layers of clothing approximate the temperature of the body, and consequently bear an important part in the retention of warmth. A practical suggestion which follows from this fact is that winter clothing should not be kept in a cold room or hall, or, if so, that it should, at least, be warmed before being donned. Otherwise bodily heat is lost in warming the clothing, and one starts out chilled. Again, clothing should be entirely removed retiring to rest at night, and each piece hung up separately in order that the absorbed perspiration may evaporate and the garments be ventilated. Moderately loose is warmer than tight-fitting clothing, on account of its inclosing a more ample stratum of air. Certain articles and customs of dress are to be condemned. All constriction is bad. Garters should not clasp the limb tightly, as they might then give rise to varicose veins, ulcers, or eczema. It is a far better plan to support the stockings by means of bands suspended from the waist. The aniline dyes of hosiery and underwear often occasion dermatitis or eczema. Irritation of the skin may also result from the blue overalls worn by workmen and sailors. Corsets, if worn at all, should never be tightly laced.

The cardinal principles of nutrition are the same for every organ or

tissue. Consequently, although much of what has preceded may seem very general, yet it is as properly applicable to the maintenance of the health of the skin as to that of any or every organ of the body. And, from the general observations upon the physiology of the skin, practical precepts as regards the care of its pathological conditions follow almost with the force and clearness of mathematical deductions. I shall not dwell upon what is obvious to the most casual attention—that there is quite a long list of alimentary substances not unwholesome in themselves, many of them not particularly indigestible, yet which act almost like poisons upon the digestive system and the skin of certain persons. I have elsewhere enumerated a number of articles which have been known to produce severe attacks of nettle-rash whenever eaten. These substances verify the old adage that “what is one man’s meat is another’s poison.” Such substances, for instance, as eggs, mutton, or orange, will in some produce annoying symptoms when eaten in the smallest quantity and although the sufferer may partake of them unconsciously. It needs not a physician to warn such a person against the article which affects him so unfortunately. But I have often had occasion, when speaking of disorders of the skin, to dwell upon the value of constitutional plans of treatment. These are often of more value than local medication. Supervision of the diet, attention to the digestion, and observation of the excretory organs are of prime importance. The question of the nature and sufficiency of the clothing must be entered into, whether the patient takes enough exercise and not too much, whether he obtains enough rest and sleep, whether his habits are cleanly, his mind at ease, his circumstances prosperous—all these matters must receive consideration in arranging a systematic plan of constitutional treatment. Rigid restriction of diet will sometimes accomplish better results than any other device. Thus a strict milk diet, or a skimmed-milk diet, may be found of more benefit in chronic eczema than any drug. In the wine-growing districts of France and Germany what is called the grape-cure has been successful in alleviating cutaneous maladies. The novelty, the freedom, the *abandon* of the life in the vineyards, must be important features—as valuable as the diet, or perhaps more so. Nevertheless, these accessories are also constitutional agencies. I may make the same remark concerning the improvement of cutaneous lesions at watering-places and mineral springs. The benefit usually depends upon a combination of agencies, among which agreeable companionship and the formation of new acquaintances should perhaps be mentioned.

The use of baths is no less valuable as a therapeutic than as a hygienic measure. Their influence upon cutaneous affections is both local and constitutional. Warm baths relieve pain, quiet restlessness, promote slumber, and, at the seat of the disease, remove inflammatory products and

the results of cell proliferation. They are also efficient aids in the treatment of parasitic disease. Tepid or warm baths have a much wider range of applicability than cold baths in these maladies. Warm baths are an excellent means of medication in psoriasis, eczema, lichen, urticaria, burns, extensive ulcerations, and pemphigus foliaceus. Turkish baths are also serviceable in the management of eczema, psoriasis, and in any disease of the skin resulting from rheumatism or gout. It is well known that Hebra met with satisfactory results in the treatment of obstinate disorders by means of the continuous warm bath. He contrived a water bed upon which the patient might lie, day and night, for weeks and months, completely immersed, with the exception of the head. A modification of this method gave striking relief in a case described by Dr. William Stokes, of Dublin. A robust man suffering from confluent small-pox was admitted to the hospital. He was furiously delirious and tore all the dressings from his face. After the tenth day he became very weak. His whole body seemed one universal ulcerous sore. In addition to the usual odor of decrustation was one of "still more intensely pungent and offensive character, which seemed to pass through the bystander like a sword." At the suggestion of a colleague, the patient was put in a warm bath. "A bath in which he could recline was speedily procured, and, pillows being adjusted in it, we lifted the sufferer in and placed him in the recumbent position. The effect was instantaneous and marvelous. The delirium ceased as if by magic; it was the delirium of pain, and the patient exclaimed: 'Thank God! thank God! I am in heaven! Why didn't you do this before?'" The fœtor immediately and completely disappeared. . . . He was kept at least seven hours in the bath," etc. This happy change was succeeded by recovery. Cold baths are also beneficially employed in the hyperpyrexia of the eruptive fevers. Warm baths form an excellent adjuvant to the specific medication of syphilis.

Many of the drugs employed in dermatological therapeutics act by virtue of their power of favorably modifying nutrition. Cod-liver oil, so effective in debilitated conditions, may be looked upon as a food quite as much as a medicine. It is peculiarly appropriate in scrofulous lesions, in the syphilodermata of weakly individuals, in seborrhœa, herpes zoster, lichen planus, eczema, and psoriasis associated with evidences of faulty nutrition, in lichen rubber, pemphigus, ecthyma, and ichthyosis. When anæmia coincides with eczema, psoriasis, or sycosis, iron is demanded. Almost any form of skin disease in a scrofulous person is improved by the iodide of iron. The tincture of the chloride of iron is one of our best remedies in erysipelas. Iodine and its combinations are of renowned efficacy in scrofula and late syphilis. Phosphorus affords relief in psoriasis, eczema, lupus, herpes zoster, and pemphigus. We rely largely upon quinine in our treatment of the eruptive fevers. Arsenic, when judiciously

used, exerts a wonderful influence, but when given without judgment it is worse than useless. Antimony, turpentine, the chlorate of potassium, are other remedies which act constitutionally. It is a commendable practice, when the stomach is irritable, to administer mercury, arsenic, or cod-liver oil hypodermatically. The latter substance is not infrequently introduced by inunction.

The removal of crusts and scabs may be hastened by warm and moist applications, such as poultices, which are excellent for temporary purposes. They relieve pain, stimulate the absorbent vessels, and prepare the way for the action of other local remedies.

Both as a hygienic and therapeutic measure, soap is required in bathing. I have already dwelt upon its use in promoting the health of the skin. As an application in disease, it is employed in its two forms of hard and soft soap, either of which may be plain or medicated. A great number of remedial agents have been advantageously incorporated. Antiseptic, astringent, and demulcent substances may be chosen, according to the indications. The earlier and cruder preparations of soda soap, such as tar, sulphur, and carbolic acid, have been succeeded by those containing eucalyptol, thymol, naphthol, oil of ergot, salicylic acid, corrosive sublimate, and boro-glyceride. Eucalyptol soap is of service in cleansing foul-smelling wounds and ulcers, and in removing the offensive odor of bromidrosis; thymol is applied in the same cases, and also in pustular eczema. Ergot soap is a valuable local remedy in eczema, acne, and rosacea; salicylic acid is used in sycosis and pustular eczema; corrosive sublimate in pruritus and syphilis; boro-glyceride in parasitic disease, in pruritus, acne, in cleansing wounds, ulcers, suppurating or gangrenous surfaces. Alum soap is beneficial in hyperidrosis, seborrhœa oleosa, and indolent affections, such as lupus, scrofuloderma, syphiloderma, and in bed-sores. Chamomile soap relieves intertrigo, dermatitis, seborrhœa, hyperidrosis, and bromidrosis. The plain potash or soft soap, either in substance or alcoholic solution, stimulates healthy action and removes crusts or scales in chronic eczema and psoriasis; it is serviceable in acne, rosacea, leucoderma, and the scrofulous and syphilitic affections of the skin. Soft soap containing tar is an excellent application in chronic eczema, psoriasis, ichthyosis, pityriasis, and seborrhœa sicca. Naphthol has the advantage of being without odor, and contributes to the relief of the same affections; it also acts as a parasiticide in scabies and phtheiriasis. Salicylic acid is efficient in hyperidrosis and bromidrosis. Corrosive-sublimate soft soap is an excellent remedy in syphilis, especially in old cases, or in broken-down constitutions and when it is badly borne by the stomach; it is also of good service in the treatment of bubo, scrofulous ulcers and enlarged glands, and in alopecia.

Oils are also approved local applications in many cases, fulfilling a number of indications. Lard, suet, and lanolin are the preferable sub-

stances made use of, and they are very variously medicated. Lanolin is the best of all, being neutral in reaction, very soft and smooth, decomposed with difficulty, and very rapidly absorbed. The petroleum fats, although they have been very largely employed, are inferior to those just named, since they are much less penetrative and are in themselves of an irritant nature. The older ointments, however, have been of late very largely superseded by a class of preparations in which a direct chemical union has been effected between a metallic base and a fatty acid—oleic. These combinations, which I have largely aided in introducing, are termed the oleates. A large number of them are now made, and they are applicable to a very wide range of indications. The oleate of bismuth is a valuable remedy in pustular eruptions, acne, and rosacea. It is also of service in erysipelas. The oleate of copper is astringent and stimulant, antiseptic and antiparasitic. The oleate of iron is styptic and astringent; that of lead is astringent and sedative; of mercury, stimulating, resolvent, and antiparasitic; of silver, stimulant. The oleate of zinc is one of the best remedies in hyperidrosis and in many varieties of local sweating, in acute vesicular eczema, and is an excellent dusting-powder in seborrhœa sicca.

Many disorders to which the integument is subject are notoriously stubborn; some are practically incurable. One golden rule of treatment, however, may be enunciated. In acute ailments avoid adding fuel to the fire. Here the general treatment should be depletory, or, at all events, unstimulating, while the local management should be mild and sedative. Severe local measures but augment the trouble. On the contrary, in chronic affections the local remedies usually need to be of a stimulant character, in order to promote the sluggish circulation of the part, strengthen the tone of the vaso-motor nerves, quicken the absorbents into activity, and favor the resumption of the physiological functions of the part.

The discovery of the vegetable parasites of the skin was among the first of those which led to the conception of the important part performed by microbes in the production of disease. In this field, therefore, we have long been familiar with the application of germicides. As investigations continue, it seems not improbable that the origin of many more cutaneous affections will be found associated with the development of microscopic organisms, and the field of antiseptic medication be correspondingly extended.

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## Society Transactions.

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### AMERICAN DERMATOLOGICAL ASSOCIATION.

THE thirteenth annual meeting of this association was held in Boston, September 17, 18, and 19, 1889, the President, DR. C. E. GRAHAM, in the chair.

The president's address was devoted principally to the subject of the

**Prophylaxis of Skin Diseases.**—After congratulating the members of the association that the thirteenth annual meeting should be held in Boston, which might not inappropriately be termed the birth-place of dermatology in this country, attention was directed to the prevention of some forms of skin disease, and especially those forms which necessitate the enactment of sanitary laws. Reference was made to the spread of scabies and ringworm, especially in schools, orphan asylums, and public institutions, and measures were suggested for their prophylaxis by the stringent enforcement of proper sanitary regulations. The prophylaxis of two most important diseases which are to a greater or less extent preventable—viz., syphilis and leprosy—was considered at length.

The history of preventive measures in various countries against the spread of syphilis, and their results, more especially in Denmark, France, and England, were then commented upon, and the difficulties encountered in their effective enforcement were alluded to.

The speaker continued: All will agree that the early diagnosis and successful treatment of syphilis, both in males and females, will have a positive effect in checking the spread of the disease. To this end it is necessary that our medical students should, during their course, devote to it a careful and systematic study. Even in our larger medical colleges, where ample opportunities are given for this course of instruction, it is to be feared that a great number of students do not sufficiently appreciate the importance of the subject to take advantage of such opportunities.

Next in importance to the early diagnosis of the disease is the provision of free and abundant facilities for its successful treatment in hospitals. This is a work in which all classes of the community may unite—viz., in the healing of those diseased. It would seem advisable to set apart wards in general hospitals for this class of patients rather than that separate institutions should be established. These wards might be placed under the control of physicians who pay special attention to this department of medicine. Every barrier ought to be removed which would in any way prevent those diseased from applying for treatment, so that patients would find it to their advantage early to enter the hospital.

The careful examination of wet-nurses by competent physicians is an important point too often neglected. A bureau for the registration of nurses, such as exists in Moscow, would be found of service in our large cities. In that institution, according to a recent report, eleven per cent. of the applicants for registration were found to be affected with syphilis.

The careful periodical examination of soldiers and sailors, and the immediate and thorough treatment when affected, are measures which ought to be easily enforced.

The spread of syphilis by vaccination and circumcision is a question which should be carefully looked into.

The question of the spread of leprosy has for the last few months excited a good deal of attention both in this country and in Europe.

The address delivered by Dr. Prince A. Morrow, before the New York Academy of Medicine, upon the history and spread of the disease in Mexico and the Hawaiian Islands, excited a general interest among professional men, while the death of Father Damien in Molokai has at the same time drawn popular attention to this subject.

Are there at present any grounds for alarm in consequence of the existence and spread of leprosy on this continent?

Should measures be adopted for its eradication, and, if so, what course is likely to be successful?

The first question may be best answered by the statement of a few propositions, about some of which the majority of scientific men are now agreed.

1. That leprosy is contagious is proved by its rapid spread in the Hawaiian Islands, by its attacking persons not previously disposed to it after living for a time in a community of affected people, and by the discovery of a distinct bacillus which is intimately connected with the existence of the disease.

2. That the disease can be conveyed from one to another by inoculation is a well-established fact. A number of cases of accidental inoculation have been reported, and the instance of the prisoner in whom the disease was produced in this way ought to set the matter at rest.

3. That the germs may be introduced with food is a probability which has been much strengthened by Mr. Jonathan Hutchinson in his papers recently contributed to the "British Medical Journal."

4. Dr. Mouritz, in his report on leprosy as it existed in Molokai, dated February, 1886, ventures the opinion that the germs may be introduced by inhalation, and cites the case of Father Damien as an instance in illustration of this theory. The instances given certainly do not seem to prove the assertion; but we are not in a position to deny its truth. A great deal of weight should be given to the opinion of one who for two years has had the best opportunities for studying the disease.

5. The hereditary transmission of leprosy was, until a few years ago, considered a settled question, and, in fact, the only way in which the spread of the disease could be accounted for. As a result of recent discoveries, the tendency of scientific opinion is in favor of the view that it is a predisposition to the malady which is hereditary rather than the disease itself.

If the disease may be conveyed by any or all of these means, how can its slow progress on this continent be explained? There are records of cases which occurred in the early part of this century, and diseased persons have been allowed to come in from foreign lands, and still there has been no decided increase until of late years.

Again, in leprous districts there are numerous instances of persons who



have lived in the closest relationship with those affected, and have themselves escaped. A marked case of this kind was reported by me in a paper on "Leprosy in New Brunswick," published in 1883.

The growth of the germ seems to depend largely upon the individual with whom it comes in contact.

In some races, for instance the Anglo-Saxon as it now exists, there do not appear to be many susceptible individuals. This is strikingly shown in New Brunswick, where the disease exists almost exclusively among the French Canadians, or those connected by marriage with that race. Even there, however, there are some patients of purely Anglo-Saxon origin.

In the Hawaiian Islands comparatively few of English or American descent have become affected.

This immunity from the disease seems to depend upon our superior methods of living rather than upon any racial peculiarities.

It must, however, be remembered that in the most favored races there are some individuals who appear to be very susceptible and who will contract the disease after comparatively slight exposure.

The conditions of the people on this continent have been such as in many ways to hinder the spread of disease. The population, as a rule, is not dense, and this is particularly the case where leprosy is prevalent. In Minnesota, for instance, the dwellings can not be very close together, and in Tracadie, although large families live in small houses, the whole district is more or less separated by miles of pine woods from other portions of the country.

Another explanation of the slow spread of leprosy exists in the fact that so far the disease has attacked other races than the Anglo-Saxon, and that there has been but little communication between affected persons and the latter race. In Louisiana and Canada the French race has principally suffered, in Minnesota the Norwegian, and on the Pacific coast the Chinese.

It is said that a wise statesman looks at least a hundred years ahead, and if in the year A. D. 2000 we should have, as some statisticians say, seven hundred millions of people on the continent, or even half that number, and if the present process of centralization continues so that our large cities should become larger than any even in Europe, how impossible would it be to control this disease if it should become at all prevalent ! It is probable that under such circumstances a large section of the community might become susceptible, and that leprosy might reach the dreaded proportion which at present exists in India.

In one respect the conditions are favorable for the extension of the disease—viz., that it exists in every quarter : in the north, in New Brunswick ; in the south, in Louisiana and Mexico ; in the west, in California and British Columbia ; while in Minnesota it is found in the very heart of the continent. Is it not possible that even now cases are coming into existence in these various localities ? Indeed, only a few months ago three cases of leprosy were transferred from Cape Breton to Tracadie, and it is quite possible that diseased persons may still exist in that part of Nova Scotia.

It would thus appear that, although there is no danger of a rapid spread of leprosy on this continent, there is a danger of its insidious propagation until it should reach proportions such as to make it very difficult to deal with.

How hard it will be for the authorities of India to stamp out the disease when, according to some, there are nearly a quarter of a million of lepers in that country !

According to statements made in a recent discussion on this subject in the New York Academy of Medicine, the number of cases on this continent has increased fivefold in the last ten years.

Would it not be wiser for the various governments at once to adopt means for the prevention of the disease rather than to wait until it has become more widely spread ?

These measures may be divided into two classes—the prevention of leprous persons from coming into the country, and the proper care of those who are already here.

To carry out the first it would be necessary that all suspicious immigrants should be examined by a physician thoroughly competent to diagnosticate the disease in its earlier stages ; and if leprosy were present they should at once be sent back to be dealt with as the authorities of their native country might determine. Doubtful cases, if allowed to remain, should be placed under surveillance for two or three years at least.

Experience has shown that the only successful method of controlling the disease in the country is the segregation of the lepers and their complete separation from healthy persons. This is a measure very difficult to carry out, even where there are but few cases, as is shown by the history of such laws in New Brunswick. In that province it was found almost impossible to compel some diseased persons to enter the lazaretto.

If such were the case where there were but few sufferers, how much harder would it be to enforce the law were the number greatly increased ! This difficulty is one of the strongest reasons why such laws should be enacted without delay.

As the disease exists in the three great subdivisions of this continent—the United States, Canada, and Mexico—it would appear necessary that an international understanding should be arrived at whereby an asylum might be established in each country, and that the law should make it compulsory for all persons in whom the disease exists in an active stage to be thus separated from the healthy portion of the community.

Such asylums should be made in every way, as far as possible, desirable places of residence, and should be placed in charge of physicians who would make a careful study of the disease. More successful methods of treatment might thereby be discovered, thus greatly benefiting the unfortunate patients themselves.

These remarks upon the prevention of skin diseases are made with the object of drawing attention to the subject, and do not pretend to be in any way exhaustive.

**Clinical Notes on Herpes Zoster.**—The title of the first paper, read by DR. F. B. GREENOUGH, of Boston. The reader had observed 255 cases of zoster during the past sixteen years out of a total of 17,741 cases of general skin disease treated at the Boston City Dispensary, making less than one and a half per cent. One hundred and forty three patients were under twenty years of age. Below the age of five there were fourteen, one being in a child of three

months. Between the years ten and fifteen there were fifty-nine, while between the ages of fifty and sixty years there were but eighteen. In the winter there were 64, in the spring 76, in the autumn 59, and in the summer months 56.

While more frequently observed in some years than in others, the average has not varied much in the sixteen years. Some factor still unknown influences the increase noticed in the springtime. The possibility of epidemics was discussed, and reference was made to what appeared to be a small epidemic, at a Boston hospital, under Dr. Bowen's observation, in which seven cases of a severe type were treated during the month of August.

The neurotic origin of the disease the reader thought had been pretty generally conceded, and there are two chief reasons for assuming it: (1) The distribution, and (2) the neuralgic pain almost always present.

The situation of the eruption was carefully recorded in 161 cases, and it was found that the costal region was affected in the greatest number of cases—viz., seventy-three times. The facial and cervical regions gave, respectively, 11 instances; the abdominal, 8; the shoulder, 4; the occipital and cervical and the aural, each 3; the finger and thumb supplied by the terminal branches of the brachial, 2; the front of the scalp, clavicular and deltoid, back, penis, pectoral, and other regions, each 1.

The symptom of pain was found recorded in 73 instances. In 17 cases no pain existed, in 19 the pain was described as very severe, and the average age of these cases was forty-four years, while the average where no pain was present was only nineteen years. In two cases in which the eruption appeared to extend beyond the median line a lateral curvature of the spine was found to account for the apparent exception. One patient, a boy, had a double zoster on the nose.

As regards treatment, the reader had found no benefit from the internal anti-neuralgic remedies. He thought the pain which often persists about the cicatrices might be relieved by cutting around the scar so as to divide the small nerve filaments.

In discussing the paper, Dr. Fox said he was glad the question of pain had been so much dwelt upon, for it was a part of the subject which students did not find properly treated of in text-books. He thought violence would be found, on close questioning, to have preceded the eruption. Some cases so clearly follow injury that there is no longer a question of cause and effect. A case may threaten to be very severe and then suddenly abort, while others of usual severity will persist (and this fact must always be remembered in weighing evidence as to the value of remedies). In one case he had seen the administration of *rhhus toxicodendron* promptly followed by a disappearance of the eruption. He had never seen any positively good results from internal remedies. He has given up collodion applications, but has found galvanism of much benefit.

After inability to sleep, the first application of the galvanism may give relief from the pain for several hours, and subsequent applications will give permanent relief, and it is possible in this way to abort the course of the disease.

Dr. Robinson said that as to the nature of the disease he could not regard

it as a neurosis, but looked upon it rather as a general infectious disease with local manifestations, neuritis, etc. He differed too from Dr. Fox, who thought it could be caused by local injury. At times it existed in greater prevalence than at others, and this too would favor his view of its being an infectious disease.

DR. ZEISLER spoke of zoster appearing during or soon after the use of arsenic. He had recently seen a case of lymphomata in which arsenic was given up to thirty drops of Fowler's solution. As the tumors disappeared a typical zoster developed. He related a case of zoster ophthalmicus followed by a complete analgesia and anæsthesia over the area of the frontal-nerve distribution, attended with itching and burning.

DR. BRONSON said there was still an unsolved mystery about this most interesting disease. Its infectious character is suggested by epidemics, etc., but, on the other hand, it does not, as a rule, depend upon time or locality, and the limited area of its distribution is against this theory, while its occurrence but once in a lifetime surely speaks for Dr. Robinson's theory. Paretic phenomena are not easily explained, such as facial paralysis occurring in zoster facialis. It is reasonable to believe that it is a reflex phenomenon. In treatment he has had successful results from the application of a solution of gutta-percha in chloroform.

DR. SHERWELL referred to three cases of zoster ophthalmicus recently seen, in which there has been an eruption upon the ala nasi. He used in treatment occlusive dressings, galvanism, and also internal remedies.

DR. HARDAWAY asked as to the possibility of chronic zoster, and related a case where, for a number of months, a gentleman had suffered from a herpes upon both sides of the neck, which recurred, was attended by neuralgic symptoms, clustering of the lesions, and all the appearances were those of zoster. The disease obeys no exact laws as to its course. Galvanism, he thinks, gives relief, using ten or twelve cells of an ordinary battery ; but he questions whether there may not be an element of imagination in some cases. He has found nothing so good as collodion and protective dressings, but does not use ointments, which macerate the vesicles.

DR. BULKLEY said the proportion of cases in New York was similar to that given by the reader of the paper. He has seen zoster in a patient who gave a history and scars of a preceding zoster. He can not at all indorse Dr. Bronson's view of its being a local manifestation of a general process. He attributed it to a simple neuritis due to cold, and at times to injury. In one case he has seen it in Pott's disease, and in another where a tumor of the neck pressed upon the nerves. He often saw it develop in cases which were under arsenical treatment. Regarding electricity, he is confident that great relief is obtained from the pain, and that more or less of an abortion takes place from its use. His constant dressing is a tight-fitting linen bandage, under which starch powder is thickly applied.

DR. HOWE said regarding treatment that the collodion dressings had given him but little satisfaction except in the erythematous form. Galvanism has in his hands given great relief. Thin strips of cork applied above and below the lesions and kept in place by adhesive strips had prevented friction, and dusting powders could be applied to the lesions themselves.

DR. KLOTZ said Dr. Kaposi had read a paper at the late congress in Prague on "Epidemics and Recurrences of Zoster," holding that these cases which recurred are different from the disease as usually seen. He could not agree with Dr. Robinson as to the infectious nature of the disease. He had seen double zoster of the face. Deep scars are sometimes left by the lesions, especially in patients who had suffered from syphilis. He related two such cases where the lesions occurred upon the brow.

DR. MORROW said he had seen at least two cases in which, after a short interval, the eruption had followed a blow. Some authors maintain that zoster does not occur below the knee. He related two cases in which the eruption was distributed over the anterior and interior surface of the leg and foot; some of the lesions were located upon the terminal phalanx of the toes. The pain in one case was localized in the knee. As to its infectious nature, many things pointed to it, while the resulting phenomenon of neuritis does not disprove it. Old people, in his experience, as the reader has remarked, suffer from more persistent pain. A hot-water bag to the spine gave immediate relief in one case which had resisted all other remedies. Contractile collodion should not be used, but the flexile is an excellent application. He is in the habit of applying a benzoated collodion.

DR. ROBINSON said he had not meant to say that zoster-like eruptions could not come from traumatism; but these cases do not prevent a real zoster from appearing, making it seem like a recurrence.

DR. GRAHAM said, regarding a fatal result, he would mention the case of a boy whom he had treated. There were febrile symptoms and pain preceding the eruption by three days; on the fourth day there was severe pain on the opposite side, and on the fifth day the patient suddenly died. The autopsy showed intense inflammation of the Gasserian ganglia on both sides, and a bacillus was found which he had not yet named, but a specimen of which he would present for microscopic examination.

DR. GREENOUGH, in closing, said he had no data regarding the influence of arsenic upon the production of zoster, but he did not think many of his cases could have been using the drug.

**Microscopical Studies of Malignant Tumors of the Skin.**—DR. HEITZMANN, of New York, read the next paper on this subject.

The author believes that in the production of tumors the tissue of the derma falls back into its protoplasmic condition, with the result of a new formation of medullary or indifferent corpuscles from which a tissue originates, either kindred to the normal structure, or the newly formed tissue remains in an embryonal condition, as seen in what the reader calls myeloma (sarcoma). This and carcinoma form the two main varieties of malignant new growth. Myeloma has two main types—*globo-myeloma* and *spindle myeloma*. The former is made up either exclusively or for the main part of globular corpuscles. Lympho-myeloma is regarded as made up of the smallest-sized corpuscles, and, according to the author's researches, furnish the structure known as fungoid mycosis. The development of *globo-myeloma* must be studied from the border of the tumor. The new formation of myeloma corpuscles takes place from the protoplasm between the bundles and from the bundles themselves. When myeloma appears in the derma a gradual thin-

ning of the epithelial covering is noticed, a falling of the hair of the part, and finally complete disappearance of all epithelial structures. The epithelia are at first transformed into larger nucleated protoplasmic masses—so called *giant-cells*—which in turn split up into myeloma corpuscles. The reader's studies of spindle myeloma have convinced him that the elements here arise from the protoplasm between the bundles and from the bundles themselves.

In carcinoma, the more malignant the type the smaller is the amount of intervening connective tissue and the more pronounced is the small-celled infiltration.

In flat epithelioma or "rodent ulcer" the epithelial nests and pegs are visible in comparatively small numbers and are far apart, due to a large amount of fibrous connective tissue between them. All varieties of cancer may appear in the skin, but myeloma does not ulcerate as epithelial cancer does. Normal epithelia is never directly transformed into cancer epithelia, there being an intermediary stage of indifferent protoplasm. We can trace the gradual transmutation of the medullary corpuscles into cancer epithelia. It is clinically of the utmost importance that the connective tissue participates in the growth of a cancerous tumor and that the so-called small cellular infiltration is a mere presage of cancer. A recurrence can be always predicted if the cut surface of an excised tumor shows shining medullary corpuscles.

DR. ROBINSON said, in discussing this paper, that the time was not sufficient to do justice to it, for it was work new in the field. He agreed with Dr. Heitzmann regarding the structure of the derma, but, so far as malignant tumors were concerned, he would make a broad distinction between tumors proper and sarcomata, which he looked upon as an infective process. Of course there is a dermatitis at the point of occurrence of the tumors in the skin and a connective-tissue new growth.

In epithelioma we have to deal with a tumor from a specialized tissue and with hereditary tendencies, and he did not think that you could get this specialized tissue from connective tissue. He did not think epithelioma could exist without previous epithelial tissue. He can not now admit that connective tissue could return to embryonal tissue and then become epitheliomatous. He has never seen an epithelioma primarily developing in a lymphatic gland, for example. He believes in the reticulum of living tissue about the bundles. Sarcomatous tissue may come from connective tissue, but in epithelioma you can not get these growths except from previously existing epithelium.

DR. HEITZMANN, in closing, said he was fully prepared to admit that early when it starts we can not tell sarcoma from inflammation. The latter stops, however, while the former goes on to form a tumor. He stands alone, he is aware, in this country in considering that epithelioma may develop from other than epithelial tissue, but he thinks the time will come when others will fall in with his views on the subject.

**The Diagnosis of Leprosy,\*** by DR. P. A. MORROW, was the first paper

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\* Will be published in a subsequent number of this Journal.

read in the afternoon session. It was illustrated by numerous photographs.

In the discussion which followed, DR. HARDAWAY asked whether the reader meant that the hairs in the patches of lepra were not changed, while in leucoderma they were always white. In his experience they were often black in patches of leucoderma. He thought most cases of lepra in this country were of the mixed type.

DR. MORROW answered that in differentiating the salient features of leucoderma and lepra he may have made a statement which was relatively rather than absolutely correct. What he meant to state was that in leucoderma the hairs were for the most part white, while in lepra they were not, as a rule. In answer to another question, he stated that in the Sandwich Islands one half of the cases were tubercular, one third were of the anæsthetic type, and the remainder mixed.

DR. GREENOUGH remarked upon the great similarity to syphilis which many of the photographs shown presented.

DR. BULKLEY asked whether in the case resembling *ulcus perforans* other lesions were present.

DR. MORROW answered that the patient had since shown other well-marked signs of the disease, and was now at the leper settlement at Molokai. He had seen this lesion as almost the only manifestation of lepra in the early stages, especially in those who go barefoot.

DR. GRAHAM spoke of a patient at Tracadie who had, at the age of seventy-one years, a perforating ulcer of the foot, and had not been in the habit of going barefoot.

The next paper was entitled

**A Contribution to Dermatological Bibliography**, by DR. G. T. JACKSON. The catalogue will be published in pamphlet form and distributed to the members. Over three thousand titles to books on skin diseases are given, and twelve hundred to those on syphilis and allied subjects.

**The Occurrence of Prurigo in America**\* was the title of a paper read by DR. ZEISLER, of Chicago.

DR. TAYLOR said, in the discussion of the paper, that he had seen two typical cases—one in a child and one in an adult.

DR. JACKSON had only seen two cases.

DR. FOX had seen two cases in adults in the marked form. He does not believe it a very rare disease.

DR. ROBINSON said he had never seen a case he would diagnosticate true prurigo in this country, though he had seen it abroad.

DR. GREENOUGH had never seen a typical or severe form of prurigo in Boston.

DR. BULKLEY said he had seen a few cases—perhaps three. He reminded the members that cases had been presented at the Dermatological Society which, under an appropriate treatment, soon got well.

DR. SHEPHERD had seen a few imported cases in Canada.

DR. WIGGLESWORTH had seen a few cases, one of which he had reported

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\* See page 408.

in Dr. Bulkley's journal a number of years ago, and last winter he showed a case at a Boston society meeting.

DR. SHERWELL said he had seen many cases in Vienna, but since being in practice here for many years he had seen but one case.

DR. BRONSON said he had the impression that a bugbear had been made of this disease. If we accept the theory that it is essentially a neurosis affecting sensory and trophic nerves alike, it is of more frequent occurrence here than is supposed. For some unexplained reason, the same thing becomes more aggravated in Vienna. He has never seen it in the adult.

DR. HOWE said he had seen three cases in the past five years since returning from Vienna. Two improved so rapidly that he concluded they were not the same disease.

DR. KLOTZ had never seen a case which disposed him to make the diagnosis of prurigo in this country.

DR. HEITZMANN said the same result was reached in this association in 1877, and the same conclusion drawn—that it was rare. He thought the disease incurable.

DR. FOX questioned this statement; he thought even in Vienna it might be cured.

DR. ZEISLER thought it strange that in his limited experience he should have seen so many cases, and the gentlemen with larger experience had seen so little of it. Curability did not mitigate against the diagnosis, especially since naphthol (beta) had been used in its treatment. Mild cases surely got well even in Vienna.

**Two Cases of Eczema Mercuriale,\*** by Dr. SHEPHERD, of Montreal.—In the discussion which followed, DR. MORROW thought the relation between cause and effect was well illustrated in these cases. As a rule, the characteristic, distinctive feature of drug eruptions is to promptly disappear upon the withdrawal of the offending cause. Still, in exceptional cases drug eruptions may persist long after the use of the drug has been discontinued.

DR. ZEISLER had seen several cases of eczema from mercury due to the ignorance of the patient in applying inunction.

DR. BULKLEY had never seen such extensive eruptions from local application of mercury as those reported.

DR. GREENOUGH thought eczema from mercurial ointment was not uncommon. In one case of his own the results were very serious.

DR. DENSLOW reported one case recently in which a decided erythema was always produced by inunctions.

DR. GRAHAM had seen the same thing from bichloride dressings.

DR. SHEPHERD had often seen a local effect from bichloride dressings, but never before so generalized an eruption.

A letter was read from Dr. Duhring regretting his absence on account of ill health.

*(To be continued.)*

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\* Will be published in a subsequent number of this Journal.



THE INTERNATIONAL CONGRESS OF DERMATOLOGY AND  
SYPHILOGRAPHY.*(Concluded from page 387.)*

DR. QUINQUAND presented two sisters affected with **Xeroderma Pigmentosum**, a morbid entity very rare in France. The lesions, as is always the case, were mostly upon the exposed regions of the body. There were general nutritive changes, and the oxygen and carbonic acid of respiration are considerably diminished in their proportions.

DR. THIBERGE also presented a case of the same affection. This was a young man of sixteen years, whose lesions had appeared at a very early age. The face is diffusely red, and covered with pigmentary stains and some telangiectases. Small epitheliomata occupy the nose and chin, and where others have disappeared cicatrices remain. The lesions increase every year, both in the cold season and in the heat of summer. The parents in this case were blood relations. An older brother has escaped the affection.

DR. DUBOIS-HURENITZ observed a case in a married man whose family and descendants remained exempt. After many operations the disease had become arrested to such an extent that he could marry. At about the age of forty he became worse, and died of an epithelioma of the face.

DR. QUINQUAND said it was usual for subjects of the disease to die at about the age of twenty-five.

DR. VIDAL recalled the case published in the "Annales de Dermatologie" (a plate of which is to be seen in Morrow's "Atlas"). When the girl who was the subject of the disease left the service she contracted variola, after which the lesions disappeared, and for five or six months one would have thought her cured, but they returned, and caused her death at the age of thirteen and a half years.

DR. SCHWIMMER cited a case in which the lesions first appeared at the age of forty-five years.

**A New Subcutaneous Mercurial Injection** was described by DR. CRUYL, of Gand, which is made by dissolving one gramme of corrosive sublimate in ether, which is then incorporated with one hundred grammes of oil. Every second day a syringe of a one-per-cent. solution is injected.

DR. ENTHYBOULE, of Constantinople, related a case of tertiary syphilis recurring periodically every spring until the whole trunk had been affected. He also read a paper on **A Case of Polymorphous Generalized Acne-like Eruption**.

**Skin Diseases in America** were discussed in a paper by DR. HYDE, of Chicago, based upon the statistics of skin affections in this country, showing the influence of our climate, especially that of Chicago, where variations extending to forty degrees are observed.

DR. UNNA, of Hamburg, gave the results of his researches into leprosy and syphilis of the nerves. The annular configuration of late roseola he compares to certain annular exanthemata of lepra, and shows that the form of lesion is related to an alteration of structure of the vessels of the skin, the latter depending upon a nerve lesion.

DR. NEUMANN said that while anaesthetic lepra was always accompanied

in the beginning by an infiltration of the nerves, syphilitic neuritis was little known. He had, however, recently seen three cases.

DR. ZAMBUCCO insisted upon the importance of nerve alteration in the early diagnosis of lepra. He makes the diagnosis from the anæsthesia which precedes all other symptoms.

**Hereditary Dermatoses** was the paper presented by DR. WHITE, of Boston, of which the following are the conclusions :

1. The transmission of peculiarities which concern the integument is carried out within the same limits as those which concern the physiological characteristics or forms of hereditary disease.

2. There exist a certain number of differences of structure in the epithelium of the skin which can be transmitted.

3. Certain tendencies toward disease of the skin may be also transmitted.

4. The list of dermatoses of which the heredity is evident is very short.

5. The hereditary disposition and the diseases of the skin disappear after a few generations, and the skin tends to return to its primitive state of integrity and health.

DR. WICKHAM, of Paris, read a paper on the

**Pathological Anatomy and Nature of Paget's Disease.**—English and American writers, the reader said, had made it clear that this disease was distinct from eczema. He has found the scales on the surface filled with parasites of the class of sporozoaires, and thinks the disease should be classed in the parasitic group.

**The Contagious Principle of Soft Chancre.**—DR. DUCREY, of Naples, concluded his paper on the experimental research into the nature of the virus of chancre with the following :

1. The chancre virus is due to an element animated and specific.

2. This virus has not as yet been cultivated, because, reduced in man to the state of purity, it is proved that its equivalent is a micro-organism which does not develop in the ordinary media of artificial culture.

3. All organisms hitherto pointed out as factors in soft chancre easily cultivable should be considered, for this very reason, entire strangers to the chancre process.

4. There exists but one form of bubo in connection with the soft sore, the simple or inflammatory form, the chancre form being nothing less than the result of accidental inoculation after the bubo has been incised.

5. The bubo should be considered as a result of the reaction of the tissues to those particular products of the vital activity of the micro-organism of the chancre.

DR. FOURNIER replied to this paper that he had made inoculation experiments under the greatest precautions, and had proved conclusively that a chancre bubo does exist, though it is not so common as the other form, and his view was generally held in France.

In speaking of **Syphilis at Constantinople**, DR. HOULKY BEY said :

1. Intramuscular injections of mercury constitute a certain and active method, because of the direct and more rapid absorption of the mercury placed in contact with the tissues. They should be preferred to all former methods.

2. They do away with the inconveniences of all other methods.

3. They permit of exact dosage.

4. They have no special contra-indications. Cachexia and diabetes are as much contra-indications for other methods as for this.

**Contribution to the Study of Secondary Syphilides of the Vagina**, by Dr. BALZER, of Paris. According to the author, syphilides of the vagina can only be discovered by careful examination with the speculum. Their favorite seat is the *cul-de-sac* of the vagina. They exist, but more rarely, in the middle portion of the canal. The papular form is the most common, but the erosive form is sometimes met with. He cited a case in which a large mucous patch of the vagina had developed from contact with the ulcerated neck of the uterus. It is important to recognize the existence of these syphilides and to search for them, since it sometimes happens that there exist no other manifestations upon other portions of the body. Their importance from the point of view of contagion can not be overestimated.

**Paludism and Syphilis**.—DR. LEPELIER, of Lille, finds that in those who suffer from malarial diseases there is a favorable ground for syphilis to develop. The principal cause is probably the cachexia it produces; but perhaps we should take into account the association of microbes. The malarial agent—which is, according to the writer, aerobian by consuming oxygen—may furnish development to the syphilitic agent, an aerobian microbe. Both diseases must consequently be treated simultaneously.

DR. ENTHYBOUL read a communication on

**Syphilitic Acne of the Nose**.—This late manifestation of syphilis is localized upon the nose, and scarcely passes beyond this organ. It is exclusively cutaneous. The first stage is characterized by successive crops of pustules upon a red and inflamed skin, resembling acne. Later on ulcerations and crusts succeed the pustules, when lupus or epithelioma is suggested. If recognized and properly treated, it quickly heals without leaving large cicatrices.

**Blennorrhagia in Women** was considered in a paper by DR. ERAUD, of Lyons. The most frequent form is essentially specific, and has for its pathogenic microbe the micrococcus of Neisser.

The site of election of the gonococcus is the urethra in women, and next in frequency it is found in the neck of the uterus. Blennorrhagic vaginitis, when it exists, is secondary to the metritis, a fact which has not been sufficiently dwelt upon. The gonococcus is infrequently found in the body of the uterus, and it is not proved that it exists in the tubes, ovaries, etc. The complications observed in the appendages of the uterus are not due to the gonococcus, but to other micro-organisms whose pathogenic rôle has not yet been fully determined. This is what has been called mixed infection, but more properly called "secondary infection." The various medications usually employed for gonorrhœa in women do not appear to have any positive effect upon the gonococcus. Because of the almost exclusive intra-epithelial situation of the parasite, a surgical treatment may well be employed. The reader had used with success a Volkmann's curette for scraping out the urethra and the uterus, after which he applied nitrate of silver or Van Swieten's liquid with good results, so far as the uterus was concerned, but with less marked benefit in the urethra.

**Treatment of Blennorrhagia by Instillations.**—DR. ROSALIMOS, of Athens, recommends Guyon's method, but prefers to make instillations each day during a fortnight. In lymphatic subjects he alternates between nitrate of silver and sulphate of copper, first washing out the urethra. He continues the treatment for two weeks after cessation of discharge.

**Recurrence in situ of Certain Syphilitic Lesions** was the subject of a communication by DR. PORTALIER, of Paris. Eleven observations had been made in which the recurrent lesion was always of the same nature for each patient. Thus one patient would have several recurrences of a tubercular eruption, another of a gumma or an exostosis.

**Syphilitic Pseudo-rhachitism.**—A work by Drs. Iscovesco and Meneaut, of Paris, on this subject was concluded as follows :

1. Syphilis at times produces osseous lesions at first view simulating rhachitism.

2. These lesions constitute a clinical form, which may be called syphilitic pseudo-rhachitism.

3. It has symptoms peculiar to itself, and is sufficient to permit of the diagnosis of hereditary syphilis.

4. It should be treated as other specific manifestations, but the results of treatment are not always satisfactory.

**The Treatment of Syphilis.**—In discussing this subject, DR. MCCALL ANDERSON, of Glasgow, said he thought treatment should only be begun when unmistakable signs have shown themselves. Mercury is not alone of value in the earlier stages, but is followed by the happiest results, often in tertiary syphilis, especially in lesions of the nervous system, and where the iodides have been tried to no purpose. Inunctions and injections are to be preferred to the administration of the drug by the mouth, when practicable. Treatment should be continued for a year after all symptoms have disappeared.

DR. LANGLEBERT said treatment should commence with the prodromata of the secondary period—headache, fever, etc.—and should be continued during the whole period of eruption. He never gives mercury in the intervals between the manifestations on the skin or mucous membranes, as he regards the drug as powerless to prevent manifestations. On the other hand, the iodides were pre-eminently suited for chronic syphilis. The average time of treatment by the iodides should be about three years. Arsenic, iron, quinine, and sulphur are of value as tonic remedies, but should be always secondary to mercury and the iodides.

**Dilatation of the Stomach in Tertiary Syphilis** was spoken of by DR. JULIEN, of Paris, who had observed a number of instances, which led him to believe that the condition could occasion many nervous symptoms which might be attributed to the direct influence of the syphilis. The administration of the iodides, the writer thought, might be the cause in some cases. Dyspepsia is usually present, and this must be the first to receive attention.

DR. DIDAY, of Lyons, believed it better to give mercury only while symptoms are present, at which time the bacilli are in activity and most easily attacked. The curative effects are, moreover, more quickly obtained ; the dose does not require to be so large ; and, as the treatment depends upon the symptoms, they are apt to be more carefully watched, and the physician thus

obtains a more thorough knowledge of the case than he would otherwise have ; besides, he will not be held responsible for new outbreaks, as he will be if he attributes prophylactic powers to the treatment carried out in the intervals ; and, finally, the patient has a greater confidence in the permanence of his cure if a period of freedom from symptoms follows each course of treatment.

DR. SCHWIMMER, of Budapest, believed that treatment should be commenced the moment the disease was recognized, and he considered it bad practice to wait until the disease was fully developed. It was not reasonable to insist upon a rigid plan of treatment for all persons in all climates. He referred to the superiority of the salicylate of mercury over the bichloride, but regarded it still as inferior to calomel injections, from which he had never seen any ill effects.

DR. NEUMANN, of Vienna, gave preference to inunctions over injections. He begins treatment when the first positive signs are present, and continues it uninterruptedly until after all secondary symptoms have disappeared.

DR. WATRASZEWSKI, of Warsaw, was opposed to injections of mercurial salts because of the local irritation they are likely to cause, as well as the danger of acute poisoning.

DR. MAURIAC, of Paris, begins treatment by mercury internally, and reserves inunctions as well as injections for special cases.

DR. KAPOSI, of Vienna, strongly opposed injections, regarding them as unscientific, and greatly prefers the inunction method.

DR. SCHÜSTER, of Aix-la-Chapelle, said that the injection of insoluble salts of mercury had never given him good results.

DR. PÉTRINI, of Bucharest, had recently made a trial of the tannate of mercury (introduced by Dr. Lustgarten, of Vienna), and was pleased with the results. He gives at first one grain and a half a day, increasing it at the end of ten days to three grains, at which dose he remains for about thirty days. Stomatitis was rarely seen.

DR. ROSALIMOS, of Athens, finds some cases in which mercury in any form, by the mouth, fails to act well. Here injections are indicated, and he thinks them more efficacious in preventing relapses. Abscesses can be prevented by care, and by making them in the rounded part of the back.

DR. DU CASTEL, of Paris, opposed injections, and feared the effects of mercury thus quickly introduced into the system, especially on the brain and kidneys.

DR. BALZER, on the other hand, upheld the method, never having seen bad effects from it, and believed injections very useful in certain cases.

DR. BERTORELLI, of Milan, said injections were much employed in Italy. He had often used calomel in this way, and was surprised to hear so much opposition to what seemed to him a good method of treatment.

**Syphilitic Contagion in the Course of the Tertiary Stage.**—DR. LANDOUZY, of Paris, cited two cases of this character. The first was a syphilitic who, since five years, the date of his initial lesion, had exhibited no manifestations, and who nevertheless communicated syphilis to his wife. The second case was that of a man affected with a gumma of the penis, and who infected his wife.

HARDY had seen two cases which confirmed the statement of M. Landouzy as to the possibility of contagion without any external manifestation.

DR. FOURNIER and DR. ARNOZAN had seen cases of contagion of syphilis during the tertiary stage.

DR. BALZER alluded to the fact that mucous patches might manifest themselves almost indefinitely in successive crops. This was probably the explanation of the transmission of syphilis during the tertiary stage.

**Relative Frequency of Tertiary Syphilis.**—DR. NEUMANN said that, from his personal experience, the most efficient causes of tertiarism are:

1. Insufficiency of treatment, both as regards dose and duration.
2. Constitutional vices, such as tuberculosis, scrofulosis, scorbutus.
3. All the causes of physiological misery.

The intensity of the tertiary lesions, he believes, is independent of the nature of the initial sclerosis, or of the secondary manifestations.

DR. DRYSDALE said that it was principally for the reason that he had come to consider mercury as possessing a prophylactic power against the tertiary symptoms that he had given up treating syphilis without mercury—a practice he pursued for a number of years.

DR. MAURIAC said a man had eighty or ninety chances in a hundred to escape tertiary lesions, unless the disease has broken out in a new geographical region, previously free, and an endemo-epidemic is established. Then the chances increase greatly.

Tertiary lesions come early in these endemo-epidemics, as they do also in hereditary syphilis. The mean average time is between the third and sixth year of the disease.

Cerebral syphilis occupies the first rank in point of frequency as well as gravity.

DR. FOURNIER thought the question one very difficult to decide. He drew the conclusions, from a twenty-nine years' experience, in which time he had treated twenty-six hundred cases of tertiary syphilis in private practice, that tertiarism may be precocious, even very precocious, even to showing itself in the first months of the disease, and, on the other hand, the numerical maximum of its manifestations correspond to the first years of the diathesis. The relative frequency of tertiary manifestations undergoes a considerable ascension from the first to the third year, when it attains its maximum.

The most curious and most important results of his researches are the extraordinary figures that the nervous manifestations attain in the tertiary stage of the pox. There is a total of 1,085 cases of various affections of the nervous system developed in the course of, and because of, the tertiary syphilis. This number is greater than that of cutaneous manifestations, or of the syphilides of mucous membranes all combined (612).

Of all the organs, it is the nervous system which, without possible contradiction, is the most often affected by tertiary syphilis—a frequency not even suspected by the author himself.

**Surveillance of Prostitution and Regulation of Syphilis.**—DR. BARTHÉLEMY stated that among the 100,000 prostitutes of Paris, only 40,000 are registered, of whom 2,000 submit to regular medical visits. The others sow the seeds of syphilis throughout Paris. He demanded that the Congress should

affirm by a vote the necessity that this liberty of propagating the contagion should not be exercised.

DR. BUTTE cited statistics showing the evident service rendered by dispensaries in checking the evil.

DR. POSPELOW stated that in Moscow no woman could be received in a house of prostitution without being provided with a sanitary card. Every prostitute must have her name inscribed and her photograph taken. She is furnished with a memorandum-book bearing her photograph, but not her name. This memorandum-book must be *viséd* every day, and bears the date of the successive visits. It may thus be easily determined whether she has been examined in the manner prescribed.

DR. BERTARELLI said that in Milan syphilis has largely increased since the application of the new law which has emancipated prostitution.

DR. CASILLO, of Madrid, thought that while regulation of prostitution was indispensable, it had never been perfectly carried out ; it is necessary to subject men who disseminate syphilis to regulation.

M. FOURNIER, of Paris, said that while all physicians concur in the opinion that syphilis constitutes a social danger of the greatest magnitude, legislators do not appreciate this fact, but assert that the statistics of countries where regulation of prostitution prevails are no better than in countries where this surveillance is not practiced. He proposed the formation of a collective committee charged to proceed to an investigation of this point, to collect all documents bearing upon the subject, in order to judge of the relative value of the regulation and non-regulation of prostitution.

This committee, consisting of syphilographers from the various countries represented in the Congress, was appointed.

Upon motion, the following resolution was unanimously adopted : The International Congress of Dermatology and Syphilography, considering that clandestine prostitution constitutes the most active agency in the propagation of syphilis, recommends that the Government impose inscription and obligatory visits upon all women who devote themselves to public prostitution.

**The Next Congress.**—It was decided by vote that the next meeting of the International Congress should be held in Vienna in 1892, and Kaposi was named president.

Socially, as well as scientifically, the Congress must be considered a great success.

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## Items.

**Asthma Sexuale.**—A. Peyer ("Berliner Klinik," 1889, Hft. 9, März) is of the opinion that disorders of the sexual apparatus, the male as well as the female, are more frequently the cause of reflex asthma than one was formerly disposed to admit. He proposes to make a distinct group of these cases, to which he has given the name *asthma sexuelle*. In the male the local trouble is usually a chronic posterior urethritis, caused by gonorrhœa or onanism, though affections of other parts of the sexual apparatus, especially the glans penis, may cause the reflex neurosis.

The author reports sixteen cases—eleven in the male and five in the female—in which, in consequence of the local treatment, a permanent cure of the asthma was brought about.

**Lupus treated with Ice.**—Klaus Hanssen ("Med. Revue," May, 1889) reports the case of a woman treated for a long time for lupus of the lower lip by means of caustic applications, scraping with the sharp spoon, etc. A cure was not effected; on the contrary, new lupus nodules developed in the surrounding tissue. At the same time so high a degree of sensibility took place in the affected parts that the slightest irritation, even the application of iodoform, caused such severe and long-continued pain that even the application of cocaine was powerless to relieve it.

The author now applied ice, as recommended by Gerhardt, with the result that within three days the pain was entirely relieved, and after the lapse of several weeks a complete cure resulted, which suffered no relapse after three months.

**Treatment of Intertrigo.**—Professor Liebreich ("Therap. Monatsheft," No. 7) recommends the following method of treating the disorder:

The affected part should be cleansed with water and a neutral soap and carefully dried, after which the following salve should be applied:

R̄ Acid. borie.....	0·5
Lanolini.....	50·0
Vaselini.....	10·0

M. Ft. ung.

Before a second application the parts must be again washed.—*Monatsheft f. prak. Dermat.*, Band xi, No. 6.

**The Treatment of Chloasma.**—The pigmentation of the face which appears during pregnancy can be caused to disappear by the application of the following salve:

R̄ Ol. theobromæ,	
Ol. ricini.....	āā 75·00
Zinc. oxid.....	0·30
Hydrarg. ammon.....	0·12
Ol. rosæ.....	q. s.

M. S.: Apply morning and evening.

—V. Monier, *Monatsheft f. prak. Dermat.*, No. 21, 1888.

**Gummata of the Tonsils.**—M. Juhel-Rénay has had occasion to observe two examples of this unusual location, scarcely mentioned by writers, of tertiary syphilis of the pharynx.

One is able to distinguish in its evolution an acute inflammatory stage simulating a tonsillitis, a period of ulceration followed by a stage of repair and cicatrization.

Its duration is indefinite; never less than from three to six weeks.

In comparing the lively reaction of the gumma of the tonsil with the indolent course of the same deposit in the soft palate, one is disposed to give to it the name acute gummatus tonsillitis.—*Archives de laryngologie et de rhinologie*, Juin 1889.

**Treatment of Barber's Itch.**—Dr. Rosenthal orders the seat of the affection to be closely shaved daily and the following ointment to be rubbed in twice a day:

R̄ Acid. tannic.....	gr. xlv
Lact. sulph.....	3 jss.
Zinc. oxid.,	
Amyl.....	3 iv
Vaseline.....	āā 5 j

M. Sig.: To be used twice daily.

In a month nothing remains of the eruption but a very slow disappearing erythema.—*Weekly Med. Review*, Sept. 14, 1889.



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## Original Communications.

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### CONCLUSION OF THE REPORT OF A CASE OF THE MYCOSIS FONGOÏDE OF ALIBERT.\*

By HENRY WM. BLANC, M. D.,

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HAVING already recorded in the pages of this Journal the main symptoms presented in the clinical history of this interesting case, together with the report of results obtained by my greatly lamented friend, the late Dr. H. D. Schmidt, there remains yet, to complete the record, an account of the last months of the disease and the disclosures of the autopsy.

In the paper referred to the last clinical note was made April 28, 1888, which found the patient still suffering from pruritus, but with the tumors confined to the extremities, more particularly the fingers and toes, on which they had never ceased to be present during the course of the disease. After this time the changes were, for the most part, for the worse, and on June 1st it is recorded that there were some four or five ulcers on either leg, irregular in shape and about the size of a silver dime. There were also several about the dependent portions of the feet—*i. e.*, near the heels, for the patient now kept his bed altogether. These ulcers were not the result of any circumscribed lesions, but rather of the general malnutrition of the congested skin. An iodoform salve was applied to them, and on July 31st they were nearly well.

In the early part of June the arsenic-and-iron mixture, which he had taken so constantly, was discontinued, without any visible result in alleviating the intense itching, when quinine was ordered to be given in doses of three grains every four hours, day and night. This had the happy effect of greatly diminishing the pruritus.

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\* See July and August numbers, "Journal of Cutaneous and Genito-urinary Diseases," 1888.

On June 23d, in the forenoon, the hair of his head fell out suddenly, leaving a circular bald space on the vertex four inches in diameter, and denuding the forehead just above the temples, on either side, for about two inches and a half. It was unaccompanied by pain or other subjective symptoms.

On August 1st patient's bowels became loose and he passed a small quantity of blood, though no arsenic had been administered for several weeks.

September 4. A note made this day states that arsenic and iron had again been attempted, but were stopped on account of the recurrence of bloody stools. During the past week the face and scalp had grown red and cedematous, the swelling serving to close the eyelids. Temperature normal. The legs also began to swell, and ulcers to appear again. Citrate of iron and quinine prescribed, and sulphate of quinine continued off and on for the pruritus, which always grew worse when this was discontinued.

September 18. Oedema of head and legs better, but forehead still swollen. Eyes are wide open to-day for first time. Oedema has changed several times lately, growing vastly better or worse within three or four hours. Appetite gradually failing. Add cinchona to the iron as a tonic.

During October patient grew visibly weaker, the appetite failed, and the pruritus disappeared permanently. No medicine administered, save chalk mixture or bismuth, for the loose bowels. Urine examined and found normal.

November 27. Patient is growing weaker every day. Left leg and foot more swollen than usual, and still ulcerated. Secretion of the fungous growths is very abundant and offensive. These parts are constantly washed with Condy's fluid.

The tumor on the left thumb has grown larger than a hen's egg. It is attached only to the terminal phalanx, completely enveloping it. During the succeeding days no new symptoms developed, the patient gradually sank into a condition of apathy, and on the night of December 4, 1888, died by asthenia. He had become much emaciated, and the hair, which remained attached, fringe-like, to the occipital portion of the scalp, had thinned considerably, leaving an appearance of almost complete baldness.

#### AUTOPSY.

The autopsy was made twelve hours after death by my friend, Dr. Henry Dickson Bruns, Pathologist to the Charity Hospital, who has kindly furnished me with the following account of the macroscopical and microscopical changes noted by him:

*External Appearance.*—Much emaciated. General discoloration of skin—light chocolate-color.

No tumors on the trunk, but here and there on the surface a number of circumscribed discolorations mark the seat of former lesions. One tumor on the anterior aspect of the right thigh (about the size of a pea) is excised and preserved for examination.

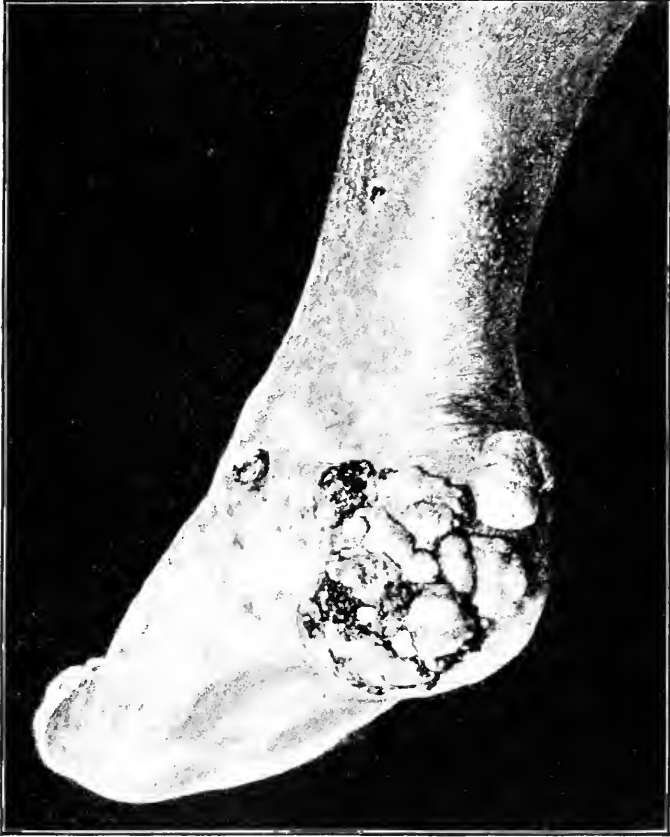
Large fungating tumor on last phalanx of left thumb.\* This tumor is about the size of a hen's egg; there is a tumor on the corresponding portion

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\* These outgrowths were all paler and more flabby in appearance after death, and about one third smaller in size.—H. W. B.

of the right thumb, but smaller. The left thumb-nail, protruding from the tumor, is greatly overgrown. There are fungating masses on all the toes and on the right heel. Portions of the large tumors of the left thumb and right heel are excised and preserved for examination.

On the anterior aspect of the right thigh there is a large irregular ulcer about the size of a man's palm. There are large ulcers on the lower half of the anterior aspect of the left leg, involving the dorsum and sides of the foot.



On the right foot several small ulcers. All the superficial lymphatic glands are involved. A large mass from Scarpa's triangle, on the right side, is removed for microscopic examination.

*Intestines.*—The large and small intestines are congested, and in places very thin. In the small intestines are many small dark spots, apparently apoplexies. There are a few small ulcers in the large intestine; the largest of these is not more than one fifth of an inch in diameter. They are of a gray color, and one has completely perforated the mucous coat. No ulcers in the small intestine.

*Kidneys.*—The left kidney presents a large prominence, comprising one fifth of the organ, upward, inward, and backward. On section through this swelling, the cortical appears thickened and of a light color. A portion was preserved for further examination. The right kidney is normal, but its suprarenal capsule seems hard and infiltrated.

*Liver.*—"Nutmeg."

*Brain removed.*—On dissection, a tumor (very soft) about the size of a dime is discovered on the inferior surface of the left cerebellar hemisphere. The pineal gland seems slightly enlarged and softened. All other organs are normal.

*Microscopic Examination.*—In sections from the tumor from the skin of the thigh, the tumor from the thumb and that from the heel, from the liver, the kidney, the suprarenal capsule, the intestines, and the lymphatic glands, a most careful search was made for micro-organisms, but none were ever found, though several methods of preparation were employed. My friend, Dr. James E. Reeves, of Chattanooga, who has been so successful in this line, was good enough to make preparations from all these tissues, but the highest powers have failed to reveal the presence of microbes.

In the tumors from the thumb, heel, and skin of thigh we find what seems to be merely a continuance, a later stage, of the processes so well described by Dr. Longstreth ("Archives of Dermatology," vol. v, No. 1, January, 1879, and vol. vi, No. 1, January, 1880) and Dr. Schmidt ("Journal of Cutaneous and Genito-urinary Diseases," vol. vi, July-August, 1888).

The stratum corneum of tumor from the thumb is thin and the fenestrated appearance figured by Schmidt (*l. c.*, Fig. 2) is pronounced. The stratum mucosum seems thickened and the nuclei have shrunk away from the formed material of the cells. This is probably due to the method of hardening in Müller's fluid, as I have seen it elsewhere. In places the papillæ are flattened or even obliterated, in others exaggerated and deformed. The connective tissue of the pars reticularis is arranged in thick cords, presenting a network with elongated, fusiform meshes of greater diameter than the cords. There is an abundant infiltration with cells—round, multipolar, and spindle-shaped. The appearances are not unlike those of Longstreth's figures (Nos. 2 and 3), but the cells are not so regularly arranged in lines, not so confined to the meshes of the network, and present a great variety of forms principally spindles more or less elongated, or transitions to the spindle form. The picture, to my eye, presents an imperfect attempt at connective-tissue formation. The lines of this network are more or less perpendicular to the surface, but here and there we find convoluted figures which seem to be Schmidt's adenoid nests, in which the connective tissue has undergone hyperplasia, while the cells have mostly disappeared. Vessels and capillaries are abundant. In many places there have been hæmorrhages, evidenced by the quantities of irregularly distributed pigment, the staining of the tissue, and extravasated red blood-corpuscles. No glandular structures are found save some infiltrated remains with thickened stroma in the lowest layers of the pars reticularis.

The tumor from the heel closely resembles that just described. The tumor from the thigh shows a further and more complete stage of this pro-

cess. Not much difference is to be observed in the stratum corneum or mucosum, but the papillæ are almost entirely obliterated. The pars reticularis consists entirely of a close connective-tissue network, of which the cords and meshes are finer and denser than in the network of the thumb and heel tumors. Scarcely any of the indifferent, multipolar, or spindle cells are to be seen—a few scattered here and there only. Long, narrow lines of indifferent cells stretching through the connective tissue are easily made out to



be the remains of the infiltrated walls of vessels and gland tubes. Deep down are some remains of glandular structures—sweat-glands mostly. At one point a few deformed papillæ, like those in Schmidt's figure No. 4, are found. Here, too, are the remains of glands (sweat and sebaceous) atrophied, infiltrated, and with the connective-tissue stroma increased, and the scattered traces of Schmidt's adenoid nests (presumably) affected in the same manner.

A section of the large intestine, through ulcerated area, shows a solitary gland with its stroma thickened, and presenting a curious vitreous appearance. The cells are arranged in dense rows (Longstreth, *l. c.*, vol. vi, No. 1,

p. 11). The appearances presented by sections of the small intestine are similar. The liver shows all the characteristics of the familiar "nutmeg liver."

In the kidney the evidences of congestion are marked. The capillaries are dilated, the epithelium atrophied, the connective tissue increased. In the elevated area, noted in the description of the macroscopic appearances of the organs, these processes are far advanced.

Nothing abnormal can be noted by me in the suprarenal capsule. The lymphatic gland is infiltrated, the appearances being those described by Dr. Longstreth. The cells are arranged in long, dense lines.

Thus ends Dr. Bruns's account. An earlier paper has expressed my views as to the nature of the case, and but little that is new remains to be said with reference to the clinical history. It is an undoubted fact that, while taking the arsenic, the tumors on the trunk were seen to disappear, and that a number of them reappeared when arsenic was stopped. This remedy, however, was powerless in its action on the fungating masses attached to the extremities, which remained till the end; but it is fair to say that, if called upon to treat another such case, I would feel compelled to resort to this remedy as likely to prove beneficial to a limited extent. The effect of the quinine was more pronounced. I had recently used it in other cases of pruritus, in which there was no apparent malarial element, and determined to try it here, as the results had been encouraging. Its action in greatly diminishing and at times destroying the pruritus was constant throughout, and it was discontinued only when this ceased to be a symptom.

In estimating the duration of the disease it is difficult to ascertain exactly when it began. The first troublesome skin affection noticed by him was in May, 1883, which he described as scaly and itchy. This was probably the beginning of the disease, and would give it a total duration of five years and a half; but, as the fungoid masses did not appear until January, 1887, that period of the disease characterized by tumor formation only lasted twenty-three months.

It should be noted that neither Dr. Schmidt nor Dr. Bruns were able to discover in the tissues any micro-organism which could be considered even as a possible cause of the disease, though both observers examined many sections for this purpose, and Dr. Bruns, at my request, has paid particular attention to this point, as his report testifies.

In conclusion, I would say that the later manifestations of this disease, together with the results of the autopsy, have not caused me to change my views materially with reference to its probable nature. That it closely resembles sarcoma in its gross and minute appearances is very true; but that it is also distinct from this disease in many important particulars is equally true. I therefore submit this case as one more contribution to the literature of the disease known as the *mycosis fungoïde* of Alibert, and, in clos-

ing, take pleasure in acknowledging the valuable services rendered me in its study by the late Dr. Schmidt, whose exquisite drawings and accurate description of the minute changes materially added to the value of the first part of this report, and which was the last piece of work that this great man ever performed for Science.

Finally, I desire to acknowledge the services of Dr. Bruns, who has so ably completed the pathological study of this case, and enabled me to offer reliable data to the future students of a most interesting disease.

42 BARONNE STREET, NEW ORLEANS.

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## A CASE OF LUPUS ERYTHEMATOSUS PRESENTING UNUSUAL COMPLICATIONS.\*

By W. A. HARDAWAY, M. D.,

Professor of Diseases of the Skin in the Missouri Medical College, and in the St. Louis Post-graduate School of Medicine.

THE patient whose case I am about to relate was a young gentleman of twenty-three years of age who, up to the time of his present illness, enjoyed average health. His father and mother, both past middle life, and his brothers and sisters, of whom he has several, are also in good health. Some time in October, 1887, Mr. H. noticed some spots on the nose, and then on each cheek. They gave him no discomfort, but, as they were objectionable on other grounds, he sought medical advice.

The practitioner whom he consulted prescribed for him a number of times without material benefit, and, finally concluding to try the effect of decided stimulation, he gave him a chrysarobin salve to rub into the affected parts. This brought about an acute dermatitis, and during this period of the case the patient fell under my care.

When I first saw Mr. H. he presented the following symptoms: His face was acutely swollen and red, but the dermatitis occupied a tolerably well-defined area, even at that time. The inflammation was to be observed on the nose, both sides of the cheeks, as far down as the angles of the mouth, and on both ears. A less intense redness, that could be readily differentiated from that just described, extended somewhat beyond these lines, but was rather of the nature of a hyperæmia. After a little sedative treatment this disappeared, and left the original area of disease quite sharply outlined.

Very naturally I ascribed the existing disorder to the chrysarobin that had been employed, and expected a complete subsidence of the inflamma-

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\* Read at the meeting of the American Dermatological Association, September 18, 1889.

tion when its effects had passed away. At the same time I was at a loss to account for the red and scaly condition of the ears, to which nothing had been applied, and experience had taught me that simple inflammations of the skin were not prone to assume a definite outline and a symmetrical arrangement. The patient's general condition was not very good at this period of the case. His bowels were obstinately constipated, his tongue heavily coated, and his breath was exceedingly offensive. After prescribing appropriate internal remedies, I ordered a lanoline and cold-cream salve for local use, and later a lanoline diachylon salve mull to be worn night and day. In the course of a fortnight the dermatitis had materially abated, and in its stead was to be noted a red, scaly, sharply outlined, and considerably infiltrated area, occupying the nose, cheeks, and ears. The backs of the hands, the palms, the sides of the nails, and also the dorsal and plantar surfaces of the feet were affected here and there with red, scaly, and slightly thickened spots.

Now, for the first time, I recognized that the disease was lupus erythematosus, the picture of that disorder, on the face especially, being clear and unmistakable. As regards the eruption itself, there was no complaint of subjective sensations beyond a slight feeling of pricking and burning. The body, except in the places mentioned, was free of eruption of any kind. As Mr. H. complained much of irregular rheumatic pains, he determined to go to the Hot Springs of Arkansas, where he remained, taking the baths, etc., for six weeks. Evidently his disease was regarded as an eczema, although, of course, he was examined thoroughly, but with negative results, for evidences of syphilis.

Upon his return to St. Louis the patient was no better of his skin affection. When he came under my care again (March 7, 1888) he presented the following appearance: The eruption was to be seen on about the same places as before. The color was peculiar and somewhat indescribable, but I presume it might have been called a very dusky red. The borders of the patches on the cheeks retained their sharp line of demarkation from the healthy skin, thus intensifying the vividness of the diseased area. Thickening was considerable, and the surface of the eruption was covered with characteristic grayish scales. The nose was slightly swollen. The hands and feet had undergone no change. He still complained constantly of deep boring pains in the limbs. By way of treatment I prescribed a salve of sulphur and salicylic acid, which was to be rubbed into the patches twice a day. For the hands and feet I ordered Klotz's plaster. Under the sulphur and salicylic-acid treatment his face began to improve, the scales lessened, and the parts looked less dusky red. For some reason, about this time I wrote him a prescription for the unguentum vaselini plumbicum. In a few days he returned to tell me that the last salve had made him much worse. Indeed, the patches looked much redder, and the



skin was considerably swollen,\* especially the nose. To allay the irritation I directed a soothing salve, and told the patient to call again in a few days. On the second day, however, I received a message asking me to go to Mr. H., as he was too sick to come to me. I found him in bed, with a temperature of  $103.5^{\circ}$  F. His face was much swollen, his lower lip was excoriated and incrustated, and there was great swelling of the lymphatic glands in the front of the neck; indeed, the natural contours of the part were entirely obliterated. There was considerable complaint of inability to swallow. On the second day the swelling in the neck was board-like in its hardness. Some eruptive spots had, in the past few days, appeared on the forehead, which were in the form of infiltrations, of various sizes, that were isolated at the periphery, but elsewhere on the brow had run together. These lesions stopped short within half an inch of the margin of the hairy scalp, and ran quite across the forehead, but in no way joined the patches on the cheeks. These patches were covered with greasy-looking, yellowish scales. On the third day the nose and ears were covered with pus-crusts of a honey-like consistence, and here and there on the cheeks were blood-crusts, as if hæmorrhagic bullæ had burst. At first blush the patient looked like one suffering from pustular eczema, with secondary lesions, etc., from scratching. On account of the throat trouble I asked Dr. Glasgow to see Mr. H. with me. He found œdema of the parts, without congestion or ulceration. Viscid mucus was secreted in quantity. At this time a crusted patch, of the size of a silver half-dollar, developed on the center of the chin, and there also appeared a crop of minute spots, some pustular, some scaly, and of a deep-red color, all over the thorax. For the next four or five days the fever ran high, reaching  $104.5^{\circ}$  F. at night, due, I think, to the adenitis. He was also very drowsy, threatening to fall into a comatose state. On April 1st the glandular swelling in the neck appeared softer, and the temperature decreased to  $102^{\circ}$  F. at night. The next day, however, another gland at the side of the neck became involved, and the fever increased again. On April 4th the gland last affected suppurated partially, and the œdema shifted to the side of the neck. During the next two weeks the affection began to improve; the lower lip lost its crusts, as did also the ears, the latter remaining, however, for quite a season bright red. The original seat of disease on the cheeks became paler, was comparatively free of crusts, and no more hæmorrhagic blebs formed. In fact, gradually, during the next month, the disorder of the skin underwent complete involution. Unfortunately for the patient, however, the lymphatic-gland involvement grew steadily worse. Gland after gland became

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\* Whether this exacerbation was due to the ointment or not I can not say, but the incompetent druggist who had compounded it merely guessed as to its composition, and had mixed certain proportions of acetate of lead and vaseline together, the result being a very irritating compound.

implicated in a tubercular process, hectic supervened, and the patient became extremely anæmic and emaciated. My friend Dr. N. B. Carson attended him from this time on, and, in spite of the most energetic and skillful surgical treatment, the affection of the glands continued. Finally the patient was taken to the sea-shore, but died after a few days, quite suddenly, of pneumonia.

It is quite a possible thing that the various local and systemic disturbances observed in this case bore no real relation to the erythematous lupus from which the patient was suffering; but, having in mind the phenomena described by Kaposi in connection with the grave form of the disease, called by him lupus erythematosus disseminatus, the resemblance seemed to me to be remarkable in many essential points. However, I shall content myself with a mere presentation of the facts in the case, leaving for some other occasion a discussion of the various reflections that it calls up.

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#### DERMATITIS PAPILLARIS.\*

By C. HEITZMANN, M. D.

ONE of the most characteristic clinical features of benign tumors is that they will not recur after a thorough extirpation, whatever surgical means be adopted. Nevertheless, there are instances, not so very infrequent, in which tumors of the skin, proved to be harmless myxomata or fibromata both clinically and microscopically, begin to reappear soon after their removal, assuming even a larger size than that of the original growth; such tumors are well known to the surgeon as recurrent fibroids. In such cases repeated attempts at eradication will prove futile; the tumor returns, its original benign type is prone to change to the worse, and a primary fibroma may, after careful surgical interference, change into myeloma under our very eyes, and even endanger the patient's life.

Similar to this is the experience of the dermatologist with certain tumors of the skin termed "moles" in a popular way, which are nothing but myxomatous or fibrous growths, always sessile, and which, after removal by means of a cutting instrument or a caustic, reappear in the shape of a luxuriant scar—a so-called spurious cheloid. I know of a case (of Dr. Nicolai) in which the careless application of green soap had caused the growth of large, branching, hard scars on the chest and the shoulders. Any suppurating wound of the skin, produced accidentally or purposely, will, under certain circumstances, give rise to a luxuriant outgrowth of so-called "proud flesh," correctly termed a hyperplastic myxomatous granuloma, with the final result of the appearance of a hyperplastic cicatrix.

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\* Read at the meeting of the American Dermatological Association, Sept. 18, 1889.

There are persons who, after slight though long-continued irritation of the skin, become subject to a growth of myxo-fibrous tumors distinctly papillary in nature, but covered with a normal epidermis, in contradistinction to papillary or warty tumors, which always are possessed of a heavy epithelial cover. A few acne pustules on the posterior aspect of the neck, on the occiput, or on the chin, may produce papillary tumors distinctly inflammatory in their origin, and therefore termed by Kaposi "dermatitis papillaris." In one of our meetings, some ten years ago, I described this form of disease in a negro, who, being in the habit of using a cylindrical cushion filled with horse-hair, and being restless while asleep, thereby caused the appearance of a number of papillary fibromata at his neck and occiput from acne pustules. Another case mentioned at that time had a similar origin. Within the last few years I treated two cases of Hebrew gentlemen affected with dermatitis papillaris. One of them was in the habit of continually picking a few acne nodules which he had on the left side of his chin, and thus gradually succeeded in producing in that place a group of papillary tumors, none of which exceeded the size of a small pea. The other, a strong, stout man, had a few acne pustules on the posterior aspect of his neck, and, through the rubbing of the collar of his coat, caused the appearance of several papillary growths of sizes varying from that of a pin's head up to that of a sugar-pea. Of such tumors some will, as a rule, suppurate in consequence of local irritation and infection with *Staphylococcus pyogenes*, and this irritation will invariably cause the spreading of the disease upward toward the occiput, should it have started on the neck.\*

What the cause of such proneness to formation of tumors is we can not tell. Von Recklinghausen announced the view, several years ago, that the growth of multiple fibromata of the cutis depends upon the distribution of the nerves. This view has been accepted as the most plausible by many dermatologists, though some of them had the courage to say that they were unable to trace the growth of fibromata as depending upon nerves. I myself was among the unfortunate ones who failed to discover nerves in fibrous tumors. The disease under consideration seems to depend upon a peculiar activity of the derma, which enables it to react upon irritation in such a pronounced way as to form tumors. Unquestionably the negro race is more liable to the production of fibrous tumors of the skin than the Caucasian. A goodly number of instances are on record in

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\* Peculiar to this form of dermatitis is the combination with scar-like, very hard, and bulging formations, which are partly smooth and destitute of hairs, partly hold bunches of strongly implanted hairs. In opposition to Kaposi, who considers the process a primary one, I maintain its origin to be from preceding papules and pustules of acne or sycosis. This agrees with the experience of Hebra, who, for this reason, termed the disease sycosis frambæsiaformis.

which pricking of the lobules of the ear for ear-rings had caused the appearance of fibrous tumors even of considerable size. That the Hebrew race is likewise prone to such exuberant tissue formations has been asserted by an experienced surgeon, the late H. B. Sands, and coincides with my own experience, the value of which, however, is not great, on account of a but limited number of cases that came under my observation. All cases of this description—altogether five—exhibited a good, nay, brilliant constitution.

If we examine the tissue of a recurrent fibroma under the microscope we observe broad bundles of fibrous connective tissue in longitudinal and transverse sections, therefore interlacing, differing from normal tissue of the same character by a large amount of protoplasm and medullary corpuscles between the bundles, sometimes so great that the type of the tissue deserves the title "myxo-fibrous." The larger the amount of such free protoplasm, the more we are enabled to assert a rapid growth of the tumor, and its proneness to change into a malignant type—myeloma. Even in hyperplastic scars, which are made up of a regularly arranged mass of bundles of fibrous connective tissue, as first shown by J. C. Warren, and coinciding with my own researches, we meet, in some places, with large masses of medullary or indifferent corpuscles, indicative of a rapid growth of the morbid tissue.

From the standpoint of a pathologist, I do not hesitate to bring recurrent fibromata into a group closely allied to cheloid and dermatitis papillaris. The papillary character is of secondary importance in such tumors, and depends merely on a certain, somewhat regular distribution of the blood-vessels in the superficial layers of the cutis.\* All these forms are dependent upon inflammatory irritation, aggravated, as a rule, by suppuration. An originally marked papillary nodule may, after repeated attempts at extirpation, become a tumor of an entirely smooth surface, and of either myxo-fibrous or myelomatous nature.

The treatment is exceedingly tedious. All strong caustics, hot iron, and all cutting instruments are forbidden, since their application will invariably cause an aggravation of the disease, or a recurrence in a form worse than the original has been. The last-mentioned gentleman was under my treatment several years ago, and, by repeated cautious applications of nitric acid, I succeeded in noticeably improving the papillary nodules. He became impatient, went to Vienna, and there was treated with knife, scissors, sharp spoon, and galvano-cautery. A few months ago he again came to my office, and now his neck and occiput were the site of sausage-like, smooth, painless protrusions of the diameter of one half to one inch, interfering with the free movements of his head backward. His report

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\* In this situation the blood-vessels, veins, and capillaries are very numerous and widened, just as we observe in warty or papillary tumors generally.

was not surprising to me, since Kaposi himself recommends knife and scissors for the removal of the tumors, whereas I am sure, from what I have seen in Hebra's clinic, that surgical interference is injurious to the patient. The gentleman thus treated is a good illustration of my assertions.

Slight aseptic irritation and cauterization seems to promote the shrinkage of such tumors. The best results I have obtained from superficial application of ordinary nitric acid and the rod of nitrate of silver. With the latter I have been successful in removing the hyperplastic scars which had grown after removal of warts on the faces of two young ladies.\* Quite recently I found the salicylic acid of value. A three-per-cent. alcoholic solution of this drug, applied with a flattened-out match or hickory-wood rod twice a day, has brought luxuriant "proud flesh" to atrophy, and considerably reduced the size of the nodules on the chin in the case of dermatitis papillaris above mentioned. A plaster or mull holding six per cent. of salicylic acid likewise proved of service in the second case. Unfortunately, neither of them has had the persistence to continue my treatment, though both were instructed to expect many months' attendance. I am unable to report a final result, and simply wish to draw the attention of the profession to this pleasant remedy, which has caused, in my hands, a lasting disappearance of granuloma and a marked improvement in cases of dermatitis papillaris.

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RELAPSE OF PEMPHIGUS FOLIACEUS (CAZENAVE) AFTER  
ELEVEN YEARS (RECOVERY).  
CASE OF IMPETIGO HERPETIFORMIS.†

By SAMUEL SHERWELL, M. D.

THE patient, Mary R., aged twenty, was born in this country of German parents. The history of the first attack in this case was reported and published, with photograph, in the "Archives of Dermatology" for January, 1877. It was also reported, as was also a relapse occurring in 1878, in a paper read by me at the meeting of the American Dermatological Association, August 27, 1878, the paper having for title "The Use of Linseed and Linseed Oil as Therapeutic Agents in Diseases of the Skin," and was published in the "Archives" in that year.

It may save comment to state that, during the first attack, the patient was carried before a very full meeting of the New York Dermatological

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\* Kaposi recommends emplastr. hydrarg. as being of some advantage in dermatitis papillaris.

† Read at the annual meeting of the American Dermatological Association, September 18, 1889.

Society in November, 1876, and the diagnosis was unanimously confirmed. It may also be as well to state that I gave, in my first report, a *résumé* of the first attending physician's history; he speaks therein of the dyscrasic condition of both parents. I think in regard to them he must have erred, as they are both robust and hearty people now; perhaps their betterment in general health may be due to their greatly improved circumstances.

The initial attack lasted from about September 1, 1876, to March, 1877. Date of my first visit, September 22, 1876. Treatment from the first and continuously was mildly protective externally, and still milder, depurative, and soothing internally. Cod-liver oil internally and as an inunction was used in great quantity, until the last two months, when, partly on theoretic, partly on economical grounds, linseed oil was used externally, with even greater freedom, and the oil and the seed internally, in various ways. Good results followed very soon, and apparently perfect recovery at the time named (March, 1877).

About the end of April, 1878, the patient having been apparently perfectly well somewhat over a year, a relapse occurred, attended with shiverings, heightened temperature, formation of large, flaccid bullæ all over the body and limbs, with the peculiarly sour-milky contents; in fact, as at the first time, with all the classical symptoms of this extraordinary disease, as given by Cazenave and Hebra. Seemingly the intensity was as great as, if not more marked than, in the original attack.

She was put on the same treatment as had been attended, apparently, with such good results in the former attack. I will not take up time in details, as they may be found in the report referred to. Suffice it to say that, by the commencement of June, she had entirely convalesced again.

This recent attack, or relapse, which gives occasion for this paper, came on in the first week of March of the present year, there having been eleven years of exemption.

I was called to see the patient on March 9, 1889, and found her grown into an exceedingly fine-looking and plump young woman. She gave a history of the same general febrile reactions, malaise, shiverings, heat of surface, anorexia, recent irregularities of the bowels—at one time constipation, succeeded by diarrhœa—had had a well-marked chill a day or so previous, since then alternate burning and shiverings of the skin. She had, however, kept at her work as compositor till the last forty-eight hours, when, in consequence of the eruption, she had stayed at home and sent for me. Since 1878 she had never needed medical care.

On examination, which she allowed to be pretty thorough, I found an erythematous condition of the skin, particularly over the chest, between and above the mammæ, on the neck, on the flexor surfaces of elbow joints, with myriads of little vesicles, about the size of a small linseed as a rule, some slightly larger, even at this time filled with the peculiar buttermilky-looking fluid so characteristic of this disease.

Temperature only moderately elevated, 102.5° F.; pulse 115. Prescribed half a bottle of citrate of magnesia to relieve a present constipation, un-

guent. aq. rosæ as a soothing and protective application, and emulsion of linseed and oil, with a little strychnine and acid. phosphorici for internal use.

On the 10th and 11th of March I found patient's condition better as to subjective symptoms; the magnesia had acted exceedingly freely; the cold-cream had relieved the tension of the skin.

Eruption had spread rapidly, covering now arms, neck, and trunk, and extending down lower limbs; a certain confluence in some places had occurred, so that thin-covered, easily-rupturing, small bullæ appeared; this, however, was the exception. The tongue and fauces showed a ragged condition, as of intense epithelial proliferation, with a sodden or softened look, and here and there small, excoriated patches, as of the site of bullæ (*vide* original history). Treatment unchanged.

March 12. In response to invitations extended to colleagues in New York, Dr. A. R. Robinson visited the case with me on the afternoon of that day. The eruption had already begun to decline much in the places first attacked, and in the extensions to have become of a milder nature, the vesicles now being almost miliary in character, though the sites of the larger could be seen, the contents always the same, however.

March 13, 14. The disease, whether by self-limitation or as a result of treatment, seems to be checked, and very evident improvement took place each day, so that, to be brief, in about ten days from last date I dismissed myself, leaving the girl apparently perfectly well.

In conclusion, I would say that the diagnosis, if it were made from this last attack alone, would have been an extremely hazardous one; but I had before attended her for so many months, the manner of attack, the contents of the vesicles, etc., were so similar, that I can have no doubt that the nature of the lesions was the same.

A word as to the two former attacks, for the benefit of those who did not see or are unacquainted with the case. The patient, in the first two attacks, had not a square inch of the body, from crown to sole, spared—not simultaneously, although nearly so all the time. On portions of the body which seemed to be trying to recover a normal condition, and relatively succeeding, there would appear bullæ, ten to twenty in number, from a half marble to walnut in size, filled with that peculiar sero-albuminous liquid like sour milk, thin-capsuled and flaccid. The rest of the body would be covered with light, dry, "*patisserie feuilletée*," "*blätter-teig*" scales, of which often a double handful might be swept up, like dry leaves, in the bed. The surface from which they had fallen was dry, and, as Dr. G. H. Fox remarked, looked, as did the general appearance, like that of a case of pityriasis rubra.

I confess I am a little astonished that the case, in recent books, should have been looked over, as it were. Certainly a more typical exemplification of the disease never existed. Its lethal failure I can not help.

## CASE OF IMPETIGO HERPETIFORMIS.

Mrs. K. (a patient of Dr. H. Risch, of Brooklyn, who furnishes a large part of this history), a brunette, aged thirty-two, a lady in moderate circumstances, and who had enjoyed excellent health up to the time of the occurrence of these lesions—never, indeed, having had any of the exanthemata of childhood—married at the age of nineteen. Has borne five living children and had several miscarriages. Only one child, a perfectly healthy boy, survives; one infant died of membranous croup, the others of various children's diseases, at between two and four years of age.

During the month of April, 1884, about a week after the birth of the now living boy, an eruption appeared on the arms and legs, attended with intense burning and itching, and general fever and malaise. She says she thinks it first came out as vesicles or small bullæ on inflamed and irritated and somewhat elevated bases—becoming, however, quickly puriform as to contents. She regained her health after a relatively short period, which continued perfect up to three years later (1887), at which time she aborted of a five months' foetus. No eruption appeared at this time.

However, in the summer and autumn of 1888, being on September 1st about three months pregnant, she began to suffer from gastric and nervous disturbances, which gradually increased until about October 1st, when she noticed a reappearance of the same lesions as those which had occurred previously, with the same objective and subjective phenomena, but more pronounced.

Dr. Risch was called in, and was inclined to consider it, from the number of excoriations and small impetiginous pustules, a case of scabies, but could not find the classic evidences of that disease. He did not, however, put her on any sulphur and irritant treatment whatever—powder of camphor and tale, zinci oxidi, etc., externally, salicylic acid internally, being the medicaments used. The eruption this time was more widely extended than at first, covering the limbs and some portions of the trunk, as the inguinal regions, etc. Crusts resembling those of impetiginous eczema formed over the surfaces most affected, darkened somewhat by blood from scratch-lesions.

The treatment seemed to have good effect; at any rate the trouble lessened in a few days: but, as the doctor was congratulating himself, another and more intense eruption appeared, and nearly the whole body now became rapidly affected. Her nervous system became so shattered that a constant tremor of body and limbs was present, and imperfect control or a sort of paresis of the latter members existed.

The same remedies were used for a time, but, having apparently lost effect, lotions containing dilute hydrocyanic acid, etc., were substituted with apparent benefit. After a couple of weeks there was some decided improvement of the symptoms, which lasted till the third week of November, the lady at this time being something over five months pregnant, when a worse relapse than ever set in, with still more aggravated symptoms.

On November 23, 1888, I first saw the patient with Dr. Risch, and found her in a pitiable and apparently dangerous condition; constant tremor pres-



ent, and shivering; moved her limbs with uncertainty and a certain difficulty; pulse weak; temperature two or three degrees above normal. The eruption seemed of a typically small impetiginous variety—different from the cases I had often seen of dermatitis herpetiformis, and seemed to spread in a sort of wave-line, peripherically or centrifugally, on an erythematous surface. On some parts of the body, as on the inguinal regions, thighs, between the mammaræ, etc., were darkened crusts.

The fact that the boy had slept for some time in the same bed with the mother and had not the slightest eruption, as had not the father or nurse, of course excluded all idea of scabies, but the eruption, as the doctor had stated, resembled it greatly in the number of small pustules, or blebs, which on my visits at least were filled with puriform material. The distinct waves of these were what most forced my attention, and I made a diagnosis of impetigo herpetiformis, and, while reassuring the dwellers in the house as to the non-contagiousness of the affection, I gave rather a grave prognosis to Dr. Risch, and suggested the possibility of having to proceed to the induction of premature labor.

I recommended continuance of the lotions, and also prescribed a favorite soothing application of my own; recommended the use of quinine, nux vomica, arsenic, and dilute nitromuriatic acid in moderate doses, and occasional exhibition of hydrarg. c. creta. This treatment was followed, and after a few days improvement occurred.

I heard from the doctor and saw the patient once, she still improving; by his permission, and in his company, Dr. G. T. Elliot, my clinical assistant, Dr. Raynor, and I visited her on December 4th. At that time, however, improvement (in one way much to my chagrin) had become so marked that many of the characteristic appearances had gone; there was chiefly now a sort of coarse furfuraceous desquamation going on, a condition of general erythema and thickening of epithelium, with pigmentation; pruritus markedly lessened; the ring-like, or rather crescentic wave-lines, which had marked the sites of old lesions, were still, however, quite manifest. Her condition went on improving somewhat till December 23d, when, after a premature labor (spontaneous), she gave birth to a non-viable child, between the sixth and seventh months, which lived three days.

From this time forth she experienced numerous slight exacerbations or relapses until about January 15, 1889. She was practically free, except a sort of furfuraceous desquamation, attended with slight pruritus; but in March, her boy having been taken down with the measles, she contracted that disease from him. She was in a deplorable condition for a while, the two troubles seeming present together; after a week or two, however, she commenced to improve, and in a month was free again, and up to present writing (August, 1889) has remained apparently perfectly well.

And now as to my reasons for having labeled this case as one of "impetigo herpetiformis," instead of "dermatitis herpetiformis" (Dühring), "herpes gestationis" (Milton, Bulkeley, and others), "dermatitis multiforme" (Am. Derm. Assoc.), "dermatitis multiformis gestationis"

(Allen), or, lastly, "dermatite polymorphe, prurigineuse, recidivante de la grosseesse" (Brocq).

I find this latter writer, in a clinical letter (September, 1889) to the editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, claims that Duhring has given up his inclusion of impetigo herpetiformis as being related in any way to the group of dermatites herpetiformis." If the fact is so, I am sorry, for I think he is right in so including, excepting always the cases that are simply frankly pyæmic or septicæmic manifestations, or epiphenomena of those conditions.

I believe, in short, that these peculiar conditions of the skin called by all these names are modifications of one and the same cause or series of causes; reflexes on the skin, either of septicæmia, pyæmia, or of effete products from any source, having primarily or secondarily their effect upon the nervous system as well. We can, I think, all see how that may happen in the sexual apparatus, in the puerperal state, etc.

I had one case a year or two since—that of a boy convalescing from diphtheria, who exhibited a marked eruption of impetigo herpetiformis on the body. Now, supposing the conditions to be chronic, what should hinder me from giving it that name?

It would seem strange, too, *prima facie*, that the only case of impetigo herpetiformis recorded as occurring in America by even so careful a writer as Crocker should be that of Heitzmann ("Archives of Dermatology," 1878), which, however, after careful reading, I can not make out to be anything like so characteristic as many others, a frank and fatal pemphigus having supervened.

Perhaps, during the last twenty years, two or three hundred thousand cases of skin lesions have passed under practical and careful observation in the United States, and yet those cases of Hebra and Kaposi are the only, or almost the only, ones recorded in literature of this peculiar disease.

As before said, I prefer to believe, then, that the affection in question, when not frankly a pyæmic or septicæmic manifestation, is a disease for which Duhring's title is perhaps one of the best terms. I think the cases, as a rule, that came under Hebra's and Kaposi's observation were manifestations occurring in persons of a cachectic and badly nourished state. Those of us who studied in Vienna twenty years ago and upward know how that could easily be, and hospital sustentation might have been better, to put it mildly. Hence extreme tendency to purulency in any lesion, and possible, if not probable, greater tendency to death.

As regards the particular case of which I have given only an abstract of the history, in most of its clinical features it resembled more nearly Hebra's disease than those so ordinarily described by Duhring, and so familiar to us all, or certainly did on the first occasion of my seeing it. The patient was prostrated and apathetic to the verge of coma—so much so

that I feared a fatal issue, in which case it would have been accepted as a case of impetigo herpetiformis without doubt. One feature or condition at my times of seeing or hearing from her was not certainly present—very high temperature. The doctor in attendance is quite vague as to this condition, so that I have every reasonable conviction that it was quite high, at times at least; but of this I certainly have no proof, which is so easy to obtain in hospital cases.

The urine was, at my instance, carefully examined at various times, and nothing specially abnormal found.

The similarity of this case to those reported by Dr. Duhring in 1884—particularly that to be found in the "Medical News," July 19, 1884; the case of Dr. White ("Boston Med. and Surg. Journal," March 18, 1889); and that of Dr. Allen ("Journal of Cutaneous and Genito-urinary Dis.," August, 1889)—all go, to my mind, to confirm Dr. Duhring's, at one time at least, expression of opinion, viz.:

"I think both the impetigo herpetiformis of Hebra and the herpes gestationis of authors should be placed under dermatitis herpetiformis, both being mere varieties of one pathological process."

I shall wait with some interest to know if Duhring really, as Dr. Brocq maintains, has given up his opinion as to their relative identity.

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 192D REGULAR MEETING.

##### DR. G. T. JACKSON *in the Chair*.

**Atrophy of the Skin.**—DR. G. H. FOX presented a case of atrophy of the skin in a male aged twenty years. Three years ago he had been struck with a base-ball in the lumbar region, just to the left of the spinal column. After the acute symptoms of injury had disappeared the skin did not recover its healthy appearance, but remained a bluish-red color. Since then the patch had grown slightly in area, the veins very distinct and enlarged, and the skin much atrophied. The disease now covered an area of about six inches in diameter, with nearly circular outline. There was no pain or subjective sensations accompanying the disease.

**Psoriasis of the Nails.**—DR. ALLEN presented a case of psoriasis of the nails occurring in a gentleman aged fifty-four. He had been suffering from the disease for the past eight years, on and off, having been entirely free from the trouble for months at a time, when he would suffer from a recurrence. He had been a constant sufferer from psoriasis of the skin, especially

about the elbows and knees, for years. The lesions usually began on the left side of the nails, half way back and extending toward the tops, causing some thickening and heaping up of dry scales beneath the detached portion. All the nails became affected, but especially those on the right hand.

DR. ROBINSON said the case seemed to him like an atrophy rather than a psoriasis of the nails.

DR. MORROW thought the case was one of psoriasis from the history and presence of psoriasis elsewhere. Most cases of psoriasis of the nails coming under his observation presented more thickening and greater fragility of the nail substance than seemed to be present in this case.

DR. FOX did not think the case was one of psoriasis, even though psoriasis was present elsewhere. He had frequently seen this same atrophied condition of the nails present in cases where there had been no psoriasis. The nails in this case, it seemed to him, atrophied rather than increased in nail tissue. On close examination, fine pits and mahogany-colored spots were observed in the nails.

DR. KEYES thought the condition of the nails might be due to syphilis, and would certainly inquire as to a syphilitic history. He had seen many cases of syphilis of the nails develop just in this way, and its tendency to spread down the sides of the nails seemed to him especially suggestive as to this cause for the disease.

DR. ALLEN concluded by saying that the patient had never shown symptoms of syphilis. He had seen the condition of the nails in previous attacks, when rounded lesions began far back beneath the center of the nail, and were not so limited to the sides. Previous attacks had been cured by applications of chrysarobin under the nails. He did not consider the nails at present atrophied; they had always been thin and somewhat brittle. The patient certainly had had psoriasis on the body.

**Cure of Lupus Vulgaris by Scarification.**—DR. ALLEN presented a case of lupus vulgaris occurring in a woman thirty-five years of age. She had had the disease since she was twelve years old. When he first saw the case, three months ago, the lupus, which was situated on the left cheek, presented an ulcerated surface the size of a silver half-dollar. The treatment had been by multiple linear quadrilateral scarification every five days. The ulceration had now entirely healed, leaving scar tissue, which seemed at present to be in a very healthy condition and was for the most part soft and white.

DR. BRONSON considered the result, although not typical, nevertheless a very good one for the length of time the case was under treatment.

DR. MORROW considered the result of treatment quite satisfactory. He was accustomed to treat his cases of lupus by scarification, and thought this method especially indicated when a destructive process was present, as in this case; the result was always more prompt and brilliant than it was in cases of lupus non-exedens. If the lupus was on the eyelid, he would use the galvano-cautery, as he was accustomed to treat lupus of the mucous membrane.

DR. ALLEN concluded the remarks by stating, in answer to Dr. Lewis, that he had treated lupus erythematosus of the eyelids by scarification with apparently good result, and would employ this plan of treatment in both lupus vulgaris and lupus erythematosus.

**Acne Cachecticum.**—DR. FOX presented a case of acne cachecticum in a boy eighteen years of age. The boy had suffered from acne vulgaris for a number of years, but four weeks ago groups of pustules and vesico-pustules made their appearance on the face, back, and upper extremity in large numbers, and accompanied with some fever. Since then he had had a number of such recurrent attacks. The lesions were rounded but not conical. The inflammation had extended from the follicles, setting up a cellulitis with the formation of abscesses, especially about the face and upper extremities. These abscesses contained a large amount of pus. The general health of the patient had been extremely poor for some time, he being anæmic and emaciated; and although, under tonic treatment, his general condition had greatly improved, the eruption had not disappeared. A few days before the acute eruption made its appearance the patient had been taking small doses of the iodide of potassium.

DR. MORROW had examined the case in its more acute stage, and its appearance suggested the probability of its iodic origin. It differed, however, somewhat from the usual iodide eruption in the extent of pustulation, the suppurative process affecting not simply the summit, but the totality of the lesion, and in its great persistency. As this cause seemed to be eliminated by the investigation made by Dr. Fox, he would regard the case as one of acne cachecticum.

DR. ALLEN suggested that some of the patches on the back looked like lichen scrofulorum, as they consisted of rounded collections of fine papules with a peculiar reddish appearance.

DR. ROBINSON saw the case in the more acute stage, when each lesion looked like an inflamed sebaceous gland. From its general appearance, anatomical seat, and distribution, he considered it a case of acne, and, if not due to the iodide of potassium, he believed it was made worse by its use.

DR. BRONSON considered the case one of acne cachecticum, but in his cases the entire follicles had not been destroyed as they were here, but ulcerations and ecchymoses were more marked. He considered the name a good one for acne occurring in anæmic subjects. He thought the iodide might have inflamed the eruption somewhat.

DR. SHERWELL also saw the case in its more acute stage, and considered it an iodic eruption. The eruption was peculiar in the size and hemispherical character of the individual lesions.

DR. PIFFARD said such an eruption might or might not be due to taking bromides or iodides. The only way to make sure of your diagnosis would be to give the patient iodide or bromide of potassium and watch its effect on the eruption. He would suggest this plan of treatment to aid in the diagnosis.

DR. FOX concluded by saying that, although he considered the term acne cachecticum a poor one, still he thought the case under discussion was a typical example of this disease both in regard to the general condition of the patient and the individual lesions presented.

**Atrophy of the Skin.**—DR. KLOTZ presented a man twenty-seven years of age, who ten years ago fell on his right knee, causing a contused wound which was very slow in healing. From that time he noticed a peculiar appearance of the skin, both in color and texture, affecting first the right leg and subse-

quently the left. At present the entire frontal aspect of the right leg from above the knee to the foot, and that of the left leg from below the knee to the lower third of the leg, also the greater portion of the lumbar and gluteal regions, showed a marked atrophic condition of the skin. The veins were enlarged and the skin of a dark bluish-red color, dry and paper-like, without any natural moisture.

DR. ALLEN presented a case of **Eczema** affecting the scalp, shoulder, umbilical, pubic, and ano-crural regions, in which latter situation the appearances were much those of an *eczema marginatum*. The patient was a German, thirty-three years of age, in whom the eruption began six years ago in the crotch. Three or four months later it appeared about the navel in a circular patch, and here it had gone and come several times. Two years ago he first noticed rounded patches on the scalp. The appearances were those of a *seborrhœal eczema*, and he had no doubt Unna would class such a case with the parasitic variety of this disease.

**Eczema Seborrhœicum.**—DR. ELLIOT presented a case of *eczema seborrhœicum* in a patient aged fifty-five years. He suffered from dandruff for years, which had produced baldness. About two months ago, accumulation of greasy crusts on vertex and formation of red patches. The lesions next appeared on hands, then on face, chest, back, and legs and feet. At present they were situated in eyebrows, on nose, upper lip, chin, and neck, and also on other portions. The lesions were characteristic in their color; sharp definition and greasy nature of scales on the greater part of them. The case when first seen showed the catarrhal symptoms in a marked degree on the hands, there being considerable weeping. The itching in the case was very severe.

**Lichen Planus.**—DR. ELLIOT presented a case of *lichen planus* in a female aged forty-one years. She had always been in good health, but subject to worry, and somewhat nervous. The eruption began on left wrist last August, and spread from thence so as to occupy the arms, extensor surfaces especially, in a more or less diffuse manner. Was likewise present on the backs of the hands. About two weeks and a half before consultation eruption appeared on neck, and also severely on lower half of back and on legs. The lesions were typical in their shape and appearance for the most part. On the arms were seen a few small circular lesions, with depressed brownish centers, and at the bend of the elbow there was a marked arrangement in *striæ*. The patient complained of headache, chills, anorexia, and severe itching. The treatment had been Unna's ointment. The effect was not marked until the  $\text{HgCl}_2$  had been increased to four grains to one ounce, when immediate improvement showed itself.

#### AMERICAN DERMATOLOGICAL ASSOCIATION.

*(Concluded from page 432.)*

**Clinical Observations on Injections of Insoluble Mercurial Salts in Syphilis\*** was the title of a paper by Dr. KLOTZ. DR. TAYLOR regarded these injections only as a fad and fashion in treatment, useful in emergency, but

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\* Will be published in this Journal.

not often found of necessity. Many observations in such methods pass for nothing, for the patients soon pass from observation. There are dangers of embolism, painful nodules, abscesses, pseudo-paralysis of the legs, and other objections which preclude the possibility of the method becoming permanently adopted.

DR. MORROW said that Dr. Klotz should be congratulated upon the good results and absence of bad effects which he had obtained. He had himself observed the extensive application of the method in Paris, and had given his views of the subject in a paper read before the Academy of Medicine. It is a reserve treatment to be applied where other methods are contra-indicated. He has seen so many painful tumors, swellings, and other disagreeable results, that he can not look favorably upon these injections in the methodic treatment of syphilis.

DR. ZEISLER had become thoroughly disgusted with the voluminous reports on this subject in the European journals. He thought the method doubtful and not applicable to cases in general. He favored inunctions for the majority of cases. He did not care to experiment with these injections on his own patients. Theoretically the method was good, but he thought not practicable.

DR. SHERWELL had gleaned from literature that the dosage was really inexact.

DR. BRONSON spoke in favor of the method in so far as it ought to be a good and scientific means of treatment, but as yet we had not learned the exact preparation to use or the way of applying it.

DR. HEITZMANN had tried the method under aseptic precautions and had obtained painful nodules and abscess, and so had given it up.

DR. KLOTZ, in closing, said his cases were all private patients who had been under observation for four years, and he had found all of these patients as grateful and even more so than those treated by other methods. Abscesses are more common in beginning the method, but as experience is acquired the danger grows less. The method has its defects, but its good qualities far outweigh them. Mercurial inunctions have done much damage by being wrongly applied, but the method remains good and is in great favor despite the teeth which have been lost and the bones which have been diseased by their faulty use.

**A Case of Lupus Erythematosus presenting Unusual Complications,\*** by Dr. HARDAWAY, of St. Louis.—In the discussion which followed, DR. TAYLOR said he had been skeptical in regard to that form of lupus erythematosus described by Kaposi. He would look upon Dr. Hardaway's case as a subacute infective process.

DR. GREENOUGH said lupus erythematosus was undoubtedly present, but he thought part of the violent dermatitis was due to local irritants.

DR. SHEPHERD said glands do inflame and become tuberculous from irritation of various kinds, and thought it might be so in this case.

DR. HARDAWAY said he did not pretend to say that the glandular enlargements were surely connected with the lupus erythematosus, but the similar-

ity of this case with those described by Kaposi was striking. The patient surely had lupus erythematosus, and the glands became tuberculous.

**A Hitherto Undescribed Form of New Growth of the Vulva.**—By DR. R. W. TAYLOR, of New York. He described two cases which had been long and carefully observed by himself at the Charity Hospital in New York. The new growth was distinct from syphilis or any venereal disease, although it might be mistaken for lupus. The growth developed subsequent to chancre, but was of a simple and benign nature and purely inflammatory.

Huguier had grouped nine cases of vulvar disease which he called *esthiomène* or lupus of the vulvo-anal region, and his views remain to-day accepted in France.

The following are the views generally accepted as the origin of simple hypertrophic and ulcerative vulvar lesions :

1. They are identical in their nature with lupus, euphoniously called *esthiomène*, a term which should be at once discarded.

2. They are the result of essential and specific syphilitic processes in the great majority of instances.

3. They are due to some indeterminate ulcerative process.

4. They may be the result of tuberculous infection.

The author does not hesitate to say that some of these views are false and others only partially true.

His own views regarding the nature of this non-malignant affection are :

1. That a large, and perhaps the greater, number of chronic deforming vulvar affections are due to simple hyperplasia of the tissues, induced by irritating causes, inflammations, and traumatisms.

2. That many cases are due to essential and specific syphilitic infiltrations.

3. That other cases are caused by the hard œdema which often complicates and surrounds the initial sclerosis and perhaps localized gummatous infiltrations.

4. That many cases are due to simple hyperplasia in old syphilitic subjects who suffer from chronic ulcerations of the vulva long after all specific lesions have departed.

5. That some cases, also in old syphilitics, are due to simple hyperplasia, without the existence of any concomitant ulcerative or infiltrative process, and seem to be caused by conditions which in healthy persons only result in vulvitis.

6. That some rare cases are those of simple inflammation, resulting from antecedent ulcerative and inflammatory conditions.

The normal appearance of the vulva in the cases described was wholly lost, and the perinæum was involved in the new growth. The surface of the neoplasm is of a maroon or chocolate color, and either dry or giving issue to a scanty reddish serum.

Microscopical examination showed the growth to be made up of simple local inflammatory tissue, according to the report of Dr. Van Gieson, who examined the specimens. Chronic vulvitis appeared to be the starting point in one case. No other affection resembles this one in its course or physiognomy. The prognosis is grave, both cases reported having died. Anti-



syphilitic treatment had been employed as a tentative measure without any good result.

DR. GREENOUGH asked if the growth was free from pressure, or showed any tendency to crop out where there was no pressure.

DR. TAYLOR answered that there was not.

DR. BRONSON said he had seen one of the cases which had, on superficial examination, resembled an epithelioma, but was shown not to be. He could not regard it as simply inflammatory.

DR. HEITZMANN, after examining the specimen, said in this instance the clinical observer was opposed to the microscopist. The process is a malignant neoplasm. The rete mucosum is not thickened, but thinned, and the papillæ are enormously enlarged. He thought the case an excellent illustration of his remarks in his paper of yesterday; he regarded it as a sarcomatous growth (myeloma). There was in this case lack of ulceration, temporary cicatrization, flatness of tumor, and death, all pointing to sarcoma.

DR. ROBINSON asked if the reader was familiar with Dr. Isaac E. Taylor's case of lupus. He had examined a specimen of that case and had found it to be a sarcoma. He agreed with Dr. Heitzmann and regarded these cases as sarcoma.

DR. TAYLOR, in closing, said he could vouch for the clinical features. He respected the opinions of those who had spoken from a microscopical standpoint. He had suspected that there was something more than an inflammatory neoplasm; but the conclusions he had reached were not hasty, and the microscopists who had reported on the sections were able men. He would be pleased to have specimens examined by the gentlemen present, and allow the question to remain for the present *sub judice*. As regards death, there was no evidence of metastatic growth; but no autopsy was secured.

The next paper was one by DR. SHERWELL, on

**Some Suggestions in Dermatological Therapy.**—*A Simple Method of treating Scabies.*—Sulphur was the drug he advocated, but the mode of its employment was what he called attention to. Dry sulphur was used, the patient dusting the body as well as the bed-clothes with it. Thus eczema and dermatitis were avoided. A mild oil, as that of sweet almonds, may be applied to the body before the dusting process. This method is especially good where all the family is affected. Eight cases have been thus treated during the past thirty days with good results.

*Eczema Ani.*—In this affection a slight fissure at the margin of the mucous membrane or, as is frequently the case, within the sphincter, is usually present. An examination with a speculum should always be made. Rubber bougies of the hard kind should be introduced for ten minutes each night. It is advisable to wash out the bowel with an enema, or a wash of sulphocarbolate of zinc, boric acid, listerine, glycerin, and water in varying proportions. Auto-insufflations by means of a long tube were spoken of.

*Eczema and Sycosis of the Upper Lip* are rebellious, annoying, and require careful treatment of the nose. Not only are the secretions acrid, but the gases of ozæna, etc., may irritate.

DR. BULKLEY spoke of the rebellious nature of these eczemas of the upper lip. He had not thought of the gases being sources of irritation, but it was a

possibility. He thought in many cases we must go back of the local nasal trouble and seek for its cause in the general system. Fissures of the anus should not be carelessly treated with silver, lest an eczema be caused. He had used a solution of from five to fifteen grains of nitrate of silver to the ounce, applied each day.

DR. ZEISLER said, in regard to eczema of the upper lip, that he thought it was so chronic because complicated by a distinct disease of the roots of the hair, and he habitually has the mustache shaved and then epilated. He looks upon the catarrh of the nose as of mycotic origin, and the affection of the lip and hairs as a direct infection. As regards sulphur in dry powder for scabies, he would fear an eczema or dermatitis would be produced by it. Kaposi's naphthol cure consists in a single application without previous bath, and only one bath three days after its application.

DR. KLOTZ shared the fear that dry sulphur would cause a dermatitis. He had often seen it do so.

DR. TAYLOR said many veterinary surgeons advised this dry-sulphur powder for the mange of dogs.

DR. SHERWELL said he had used the dry sulphur for eight years, and had not seen bad effects produced; he did not use rough friction. He thought the treatment original with himself.

**What Real Value have Mineral Waters in the Treatment of the Skin**, was the title of a paper by DR. L. DUNCAN BULKLEY.

In some waters the medicinal qualities are curative in a measure from their action on certain organs of the body, but, as a rule, their use is most disappointing in skin diseases, and no great dependence is to be placed in them. Some amelioration is effected by sulphur waters, but it is chiefly the water which benefits when taken internally. In some purely external affections a local effect of the sulphur may take place, but usually only in a slight degree. Most patients who seek relief from mineral waters are eczema cases, but the chronic cases are those most benefited. The reader makes most use of the White Sulphur Springs in this country, followed by a short course at the Old Sweet Spring.

The Hot Springs of Virginia have but little effect on psoriasis. Acne is but little benefited by sulphur waters, while iron springs, such as the Poland Spring in Maine, do more good. The good obtained by previous treatment is often undone at springs by the life too often led by health-seekers.

DR. HARDAWAY said his own experience had been in a way large, as he had lived near the Hot Springs of Arkansas, and the Eureka Springs. He had seen benefit, but he could always explain it by other influences than the mineral ingredients of the water. The water itself was of great value in those who needed treatment for internal disorders. Inveterate cases of psoriasis can have the scales readily removed by the packing treatment, but it has no more effect on the ultimate cure of the disease than other plans of treatment. The adjuvant treatment is that which does good.

DR. KLOTZ regarded the water as the adjuvant, and mercury as the principal treatment, at the spring resorts so well thought of for syphilis. The amount necessary to sufficiently improve our springs would not at the present time repay the outlay.

DR. TAYLOR spoke of the Saratoga Springs. It was not an ideal resort because of the social attractions. He had never seen any marked effects from the Saratoga waters, but had learned to advise those with kidney or renal complaints not to drink the Hathorn water.

DR. SHERWELL said he was glad to hear the harm these springs may do so justly spoken of. He had seen their bad effects in several cases during the past year.

DR. DENSLOW spoke of the climate at St. Paul, from which many chronic patients go to the hot springs of Montana or of Arkansas. They are usually benefited, because they either avoid the water or use it very judiciously. He had seen some of the evil effects spoken of.

DR. GRAHAM said those cases in his own experience which received benefit are those complicated by rheumatism. He spoke of the Preston Spring, in Canada, at which some of his patients with eczema, etc., did well.

DR. BULKLEY, in closing, said he had thought the Missisquoi Spring, in Vermont, of benefit in cancer. The water contained a little silica, which was a remedy supposed to have some effect on epithelioma.

**Dermatitis Papillaris\*** was the title of a paper read by Dr. HEITZMANN, of New York.

DR. FOX, in discussing the question, said he had seen one of the cases reported, and advised, according to Kaposi, to remove the growth. This was objected to, and electrolysis was employed. There was some suppuration about the bundles of hairs. The progress was slow, but the size of the growth was decreased. Last spring the patient was seen again, and the growths were larger, after having been removed with scissors and knife in Vienna. Since then he had treated an almost duplicate case on the occiput of a negro, which suggested keloid in a measure, and he had been led to believe it clinically the same affection as keloid modified by its location. As to treatment, electrolysis was a failure, while in some cases of keloid it seemed to do good. He thought the salicylic treatment, as suggested, worthy of trial.

DR. BULKLEY recalled a case in a negro which improved under mild treatment.

DR. ZEISLER had seen one of the reported cases. The name had been given by Kaposi, and any one using it should conform strictly to the original descriptions.

DR. GREENOUGH referred to a case in which keloid resulted from croton-oil applied to the chest.

DR. KLOTZ thought a five-per-cent., and even ten-per-cent., salicylic plaster would not be too strong in such cases.

DR. JACKSON had had an unfortunate experience with salicylic acid in a papillomatous growth upon the cheek of a lady, but other forms of treatment likewise did no good.

DR. DENSLOW spoke of the uselessness of electrolysis in such keloidal growths upon the hand.

DR. GRAHAM had had a case under observation for four or five years, which appeared to him to be this disease. Sycosis had preceded the growths

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\* See page 450.

in the beard, and keloidal growths followed lesions of sycosis, under the speaker's observation. Keloidal growths followed an injury in the same subject.

DR. FOX said he was glad to learn that the microscope showed identical appearances with keloid, just as the clinical features showed it to be the same.

DR. ZEISLER then read a paper entitled **Clinical Notes on Sycosis**.<sup>\*</sup> In the discussion which followed, DR. ROBINSON said, as regards sycosis of the scalp, he thought it existed, and in many cases the lesions are isolated and the secretion serous. He did not believe that the pus organisms had anything to do with its production, as many lesions were not pustular. He looked upon pustulation as secondary and accidental, and thought treatment should not be so much directed against it. He suggested a predisposing cause, of more importance than the exciting cause. The ground must be made unfavorable for the cocci by internal treatment, or by treatment of the eczema which precedes it.

DR. BULKLEY spoke of inflammatory conditions about the hairs of the scalp not preceded by any eczema or other disease of the scalp, and in which each follicle was sealed by a small scar after the process was at an end. The cases were very obstinate. The lesions did not group, but resembled such a folliculitis as was seen in the beard. He regarded it as constitutional.

DR. DENSLOW spoke of a case seen during the past year in which the hair was very thick and deep-seated abscesses had existed for years, causing loss of hair. The scalp was continuously hot and burning. He considered that the soil was at fault, and regarded it as a case of acne of the scalp. There was no syphilis in the case. Large doses of ergot acted with very good effect.

DR. KLOTZ agreed with Dr. Robinson that pustules were not essential in sycosis. Pustules on the upper lip should not be called sycosis.

DR. HEITZMANN asked if Dr. Bulkley's cases were not acne varioliformis.

DR. BULKLEY said No; that he had written of acne atrophica, in which the lesions ran up into the scalp from the face.

DR. HEITZMANN recalled Dr. Atkinson's paper of ten years ago on kerion celsi, in the discussion of which he had spoken of hyperplasia as resulting from other causes than herpes tonsurans, etc.

Why should the term kerion be used only to multiply names, if the process is the same and the same scars are left?

DR. ROBINSON said, regarding the name, that it was based on the seat of inflammation. The process was similar, and the clinical history was similar.

DR. GRAHAM once had an experience which led him to the conclusion that the disease was not always local. A patient with sycosis acquired typhoid, when the sycosis disappeared, to recur as soon as the patient recovered.

DR. ZEISLER answered that he knew how, during febrile disturbances, efflorescences on the skin disappear. He did not think there was any retrogression of the disease into the system. The same thing was seen in scabies, eczema, and other diseases during fever, as Kaposi had pointed out.

As regarded the name, we knew that acne, eczema, and sycosis were dis-

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<sup>\*</sup> Will be published in a subsequent number of this Journal.

inct diseases, but in his cases the sycosis on the scalp was so similar to that seen on the face that he had so named it.

**Impetigo Herpetiformis and Relapse of Pemphigus Foliaceus after Eleven Years' Quiescence** was read by DR. SHERWELL. (See p. 453).

In the discussion DR. HEITZMANN asked how it was that if pustules from the first were necessary for the diagnosis of impetigo herpetiformis, this could be considered the same, since it was stated that vesicles were first seen.

DR. ZEISLER had observed a classical case, already published, showing that the disease was seen in this country. He watched it closely for three months, and believed impetigo herpetiformis to be a disease *sui generis*.

DR. ROBINSON had seen the subject of the reader's first paper, and there was no doubt of its being a case of pemphigus foliaceus.

DR. HARDAWAY said pemphigus foliaceus was so rare he would relate the history of a case developing on the chest and progressing slowly for several months, when it resembled wholly a pityriasis rubra which he had at the same time under treatment.

In closing, DR. SHERWELL said he regretted not having read of Dr. Zeisler's case. In his own case, although the lesions were not all pustular from the first, some were.

DR. BRONSON then read a paper describing **An Unusual Form of Pustulo-Ulcerative Disease of the Skin**. (See p. 401.)

In discussing the next paper, on **Urticaria Pigmentosa**, by DR. STELWAGON, of Philadelphia, which was read by the secretary in the absence of the writer, DR. FOX said he thought the disease incorrectly named. He did not regard the urticaria as the essential element in the disease, but looked upon the pigmented spots as presenting the main changes.

DR. HEITZMANN objected to the view that it was a disease *sui generis*, but was willing to admit that it was a tropho-neurosis. The yellowish tint proved that with the exudation there was an admixture of blood, and hence the pigment. He regarded it as a simple urticaria plus blood in the wheals.

DR. KLOTZ asked why the hæmorrhages remained as pigment spots, and were not absorbed, if the latter view were correct.

DR. HEITZMANN answered that under chemical change a pigment was produced which was not easily absorbed, and was identical with the pigment found in melanotic sarcoma.

DR. TAYLOR spoke of the disease as occurring in old age. One resembled the pigmentation which followed a syphilitic roseola.

The next paper was by DR. HARDAWAY, on **Dermatological Notes**.\*

DR. HEITZMANN said that it was a mistake that he had predicted death in the case, as the pigment was diffuse and not granular in the specimen he had examined, and he had said that the process would be slow. The cases of papillomatous growth in syphilis were very rare. It does not mean anything especially.

DR. GREENOUGH asked the reader whether the last case might not be a chronic urticaria.

Ans. There was no pruritus.

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\* Will be published in a subsequent number of this Journal.

DR. TAYLOR said, in reference to the bullæ of pemphigus, that they could occur as rhombs and parallelograms. He had at first thought such a case which he had seen a feigned eruption, but it proved not to be. It occurred subsequent to a severe operation (laparotomy).

DR. BRONSON said, in regard to sarcoma, that in a case which he had carefully observed there was pain of the most intense character. The patient died, but no autopsy was permitted.

DR. GRAHAM read a description of the sections of the Gasserian ganglia, taken from the **Case of Fatal Herpes Zoster** reported in yesterday's session. One section showed within a blood-vessel a mass of bacilli stained by Gram's method. Leptothrix-like cells in bunches were to be seen within the arterioles. Diplococci were also seen just after staining. Leptothrix in the sheath of the ganglia. No micrococci or bacilli were found in other parts of the brain or medulla.

DR. HEITZMANN said he had been in hopes we were about to find out what herpes zoster really was. The micro-organisms seen here appeared to him to be new ones, and if cultures could be made it would settle the question.

A paper on **The Alleged Tolerance of the Iodides in late Syphilis**, by DR. STELWAGON, was read by the secretary. The author claimed that the tolerance was no more marked in syphilitic than in non-syphilitic patients. A number of cases were reported to illustrate how frequently the iodide was not well supported. His own experience corresponded with the observations of Haslund, that large doses could be given in psoriasis with an equal freedom from the production of iodism seen in syphilis.

DR. TAYLOR said, in the discussion, that Wood's conclusions drawn from nervous cases were faulty. The iodides were equally intolerable to certain syphilitics and non-syphilitics alike, but we were apt to give up their use too early when the first symptoms of coryza, etc., show themselves. Sometimes the drug could be pushed without danger.

DR. GREENOUGH said some patients would bear large doses when they could not take small ones.

DR. DENSLOW added his experience in one case in which there was undoubted syphilis, and in which the patient could not stand even a two-grain dose of iodide of potassium.

DR. SHEPHERD had found the iodide of ammonium to be tolerated when potassium iodide was not.

DR. BULKLEY spoke of conjoint administration of arsenic to make the iodide and bromide of potassium tolerant.

DR. TAYLOR thought much could be done to prevent bad effects by thoroughly cleaning out the primæ viæ and keeping the patient on a low diet during the course of iodide. If arsenic had any indication, it was in the dermal inflammations caused by the iodides.

DR. BRONSON corroborated the statement that arsenic had no effect on the coryza, but did prevent acne.

DR. HARDAWAY said he had treated many epileptics who had taken bromides in large doses, and had never seen any benefit from the admixture of arsenic. Iodide, given before meals, had a double efficacy, according to some authorities.

DR. FOX said he had had iodic and bromic acne under treatment. If arsenic was combined at the time when the drug was tolerated, as it was at times more than at others, we attributed the result to the arsenic. He had not succeeded in demonstrating the worth of arsenic in these cases.

DR. TILDEN then presented a case of **Prurigo**, which was acknowledged to be a real case of Hebra's prurigo by Dr. Zeisler and others.

DR. BRONSON said the patient had eczema unquestionably, but also prurigo. The essential point in prurigo was the local neurosis affecting certain regions.

DR. BULKLEY referred to the statistical report for this year, showing one case reported from New York and six from Chicago.

DR. FOX thought this a true case of prurigo, but he doubted if it should be separated from papular eczema. There was in this case a superadded eczema. The only difference between this disease and eczema was the question of its duration.

DR. ALLEN spoke of a case of true prurigo now under his care in New York, which was almost the counterpart of the case presented.

DR. BULKLEY said this disease had been thrown into the class of eczemas in this country, and he thought that it should be taken out of the eczema group. He predicted a great increase in the recorded cases in the next few years.

DR. GREENOUGH said this was the only case he had seen in this country. Since Dr. Zeisler's remarks he was convinced that cases put down under other names might have been really cases of prurigo.

DR. ZEISLER said this was a typical case of prurigo ; he could almost make the diagnosis from the appearance of the patient's face. It was not so very common in Vienna as generally supposed. He said he could not understand how this could be regarded as an eczema ; the differences were very striking. A papular eczema would always show the face, hands, and scalp affected, while in prurigo, as illustrated by this case, these regions were free.

DR. FOX replied that, so far as the retention of terms was concerned, Dr. Zeisler's remarks would apply to the old term lichen, now included under papular eczema. In its essential features and natural history this disease should be separated from papular eczema.

The next meeting will be held at Richfield Springs, N. Y., September 2, 1890.

The officers elected for the ensuing year are as follows : President, Dr. Prince A. Morrow, New York ; Vice-President, Dr. G. H. Tilden, Boston ; Secretary and Treasurer, Dr. G. T. Jackson, New York.

Two new members were elected—Dr. J. T. Bowen, of Boston, and Dr. Charles W. Allen, of New York.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

#### **Nature of Alopecia Areata and its Treatment by Appropriate Antiseptics.**

—Upon several occasions I have spoken on the subject of the aetiology and pathology of alopecia. Works on this question have been multiplied in France since the day when Dr. Ollivier and Dr. Gaucher thought it their duty to claim admission of children thus affected into the public schools without any conditions being placed upon them, on the pretext that the disease was purely of nervous origin and not contagious. I was at that time the first to protest against such conclusions, and in an article, which subsequent writers have perhaps a little too much overlooked, I related in the "*Gazette hebdomadaire*" several cases of undoubted transmission of alopecia areata from affected to healthy individuals. My conclusions, which may be found in my letters of 1887, were to the effect that these forms of alopecia had undoubtedly various modes of origin, that there were probably some of nervous origin, and consequently non-contagious, but that there were also, without doubt, some of a contagious nature which should have a recognized cause in some parasite or other. Among the French authors who have occupied themselves with this question, some have adopted my theory, to which I gave the name "the mixed theory," and among such observers I may cite Dr. Thibierge, Professor Leloir, of Lille, etc. Others more decidedly have only admitted the parasitic theory. Dr. E. Besnier, in his admirable report to the Academy of Medicine, believes that the contagious element determines a tropho-neurotic trouble in the nutrition of the hair. In his recent communication to the International Congress of Therapeutics, held in Paris in August, 1889, Dr. Hallopeau is still more explicit. So far as he is concerned, "although the parasite of alopecia is not known, the clinical facts permit us to affirm its existence and to determine its location. It exists upon the surface of the hairy scalp, as is shown by cases of transmission, but it accumulates especially in the hair papillæ, which explains why the transmission is less easily effected than in the case of trichophytosis, and why it is necessary that there should be intimate and prolonged contact between the contaminated region and the carriers of contagion—shears, pillows, cushions, head-wear, etc." It is further necessary to take into account here, as in all parasitic affections, the variable conditions of receptivity which different subjects possess.

Starting out from these absolute principles, we understand what ought to be the treatment of alopecia according to Dr. Hallopeau. As regards general prophylactic measures, he recommends the same measures as those approved by Dr. Besnier, and mentioned in previous letters to this Journal. It is not rare to see the disease suppressed in its original situation and reproduced at another point upon the patient's head, thus illustrating auto-contagion—the microphyton having been transported outside of the primitive plaque and multiplied at a new point of inoculation. It is therefore necessary, to prevent these possible extensions and recurrences of the disease, to take the most



minute precautions. As often as one can, the hairs should be cut short and parasiticide lotions applied upon the whole scalp. As regards local treatment, Dr. Hallopeau prescribes for washing the healthy regions an alcoholic solution of turpentine to which 1-to-1,000 of corrosive sublimate has been added. He employs this also in the treatment of plaques which have become denuded, when they are too extensive to be subjected to the much more rapid action of vesicants. The vesicatories in the liquid form are much preferred by Dr. Hallopeau, especially the blistering fluid of Bidet. This preparation has been highly vaunted by Dr. E. Vidal. A layer is painted over the diseased area and should produce a commencing blister. If the effect produced has, however, not been sufficient, two coats are painted on. If, on the contrary, the vesication has been severe (a thing to be avoided, so as not to destroy the hair bulbs), chloroform is to be added to the vesicating fluid to render it less energetic. In fact, the epidermis is more or less sensitive in different individuals, and hence the preparation of the liquid of Bidet is calculated in such a way that, painted on in one layer, a very marked rubefaction and a beginning vesication is produced in most cases, two coats cause moderate, and three intense blistering.

**The Inoculability of Psoriasis.**—Dr. Augagneur and Dr. Destout, of Lyons, think that they have demonstrated the inoculability of psoriasis. They have observed the development of this affection upon the vaccinal eruption of two children, and, furthermore, Dr. Destot has made the following experiment upon his own person: On the 9th of May, after washing his right arm with ether in the region of the insertion of the deltoid, he made an incision into which he inserted a complete plaque of psoriasis removed from the arm of a child. Two days after the operation, papules appeared upon the left elbow, and subsequently upon the elbow of the right side, and took on, some days later, the most decided characteristics of psoriatic patches. The diagnosis of psoriasis was confirmed by the members of the Society of Medical Sciences of Lyons, before whom Dr. Destot presented himself. It is needless to add that before the inoculation was practiced he had shown no trace upon the body of any psoriatic eruption. This experiment, according to the authors, tends to prove that there occurs in psoriasis a general affection of the economy by inoculation and a transfer to distant points of the infectious agent by means of the circulation, since the first manifestations of the disease showed themselves at a point quite separated from the point of inoculation. They believe that in this observation they have a demonstration of the parasitic theory of Lang. On my own part I can not make known to you these curious results obtained by the Lyons school without accompanying the report with some remarks. In the first place, this inoculability by general infection of the economy, as the authors say, in no wise confirms the researches of Lang and of other dermatologists, who have till now upheld the parasitic theory of psoriasis. In fact, for Lang and his disciples the parasite of psoriasis is a fungus of epidermophyte nature vegetating on the surface of the integument and in a sense exterior to the organism. According to Dr. Augagneur and Dr. Destout, on the other hand, the parasite of psoriasis is some kind of a microbe which penetrates into the circulation and infects the whole economy, thus representing an internal infectious agent. Thus we have two conceptions totally different, the Lyons

theory being absolutely new. Are we authorized to accept it at the present time as proved by the facts of the case? We do not think so. We believe that more than one inoculation is required, and positive results must be obtained in subjects in no respect predisposed by heredity to psoriasis before we can admit it in a definite manner. The instances of non-contagion are so numerous, the facts of heredity alternating or collateral with transformation into other morbid manifestations in intermediary subjects are so well known, the evolution even of the affection agrees so little with the hypothesis of a parasitic origin, that a single case of inoculation, which may, after all, possibly be but a coincidence, can not suffice to convince us.

**Treatment of Psoriasis by Large Doses of Iodide of Potassium.**—All dermatologists know at the present time that Haslund, of Copenhagen, has obtained cures in psoriasis by the administration of the iodide of potassium in very large doses. Analogous successes have already been published in different countries, but we must admit that in France, either because of timidity on our part or because of the greater intolerance for the drug shown by patients in this country, we have not been able to cause the drug to be supported by the majority of psoriatics in the enormous doses necessary to obtain a good result. Here, however, Dr. de Molènes has published in the "*Archives générales de médecine*" two cases of psoriasis which he has successfully treated by the Haslund method. The first of the patients took, in progressively increasing doses, 1,117 grammes of the iodide of potassium in nine weeks; the second, 1,751 grammes in forty days. The drug was very well borne by the patients. The author advises that, before such large doses are resorted to, the stomach, intestines, and especially the kidneys, be carefully examined.

**The Abortive Treatment of Herpes by Application of Alcohol and Alcoholic Solutions.**—Dr. Dupas, of Lille, has, under the inspiration of Professor Leloir, just published a thesis upon this subject. Alcohol of ninety-per-cent. strength, or a solution of two parts of resorcin to one hundred of alcohol, can be employed as a dressing, or, again, one gramme of thymol, or three grammes of menthol, or twenty-five centigrammes of phenic acid, or two grammes of tannin to one hundred of ninety-per-cent. alcohol. If these solutions cause too much pain, a little cocaine may be added. Compresses wet in one of the above are to be applied upon the lesions, and over this is spread some impermeable material. Absorbent cotton may likewise be used. These dressings must be changed quite frequently during the day. Under the influence of this treatment the herpetic eruption is seen to abort quite rapidly, in the course of a few hours sometimes, if made at the onset. If the herpes has already reached the period of suppuration, the vesico-pustules and pustules disappear by drying up with rapidity and no new ones are produced, while the surrounding redness diminishes with equal rapidity and the duration of the attack is much shortened. The element of pain is equally reduced, and it is not rare to see rebellious neuralgias of herpes zoster give way in a few hours by the employment of this method.

**Treatment of Simple Chancre with Resorcin.**—Dr. Leblond, physician to the St. Lazare Hospital for venereal diseases of prostitutes in Paris, has been experimenting with resorcin in his service in the treatment of chancroid. He

has the ulcer sprinkled each day with powdered resorcin, and the following morning the surface is gently cleansed. So long as the base of the sore has a grayish color he continues the applications. In general, at the end of five or six days the whole surface of the wound has taken on a rosy hue and shows healthy granulations. A dressing is then applied consisting of a five-per-cent. solution of resorcin, and cicatrization quickly follows. Further, the author remarks that as soon as the sore is well cleansed and no longer presents a characteristic gray base, any appropriate dressing will bring about a rapid cure. The resorcin is thus only useful, like pyrogallie acid when thus employed, to transform the virulent chancre sore into a simple ordinary wound by destroying the contagious and inoculable agent. When the chancre is recent, resorcin will cure it in a fortnight, and it is rare for adenitis to develop in these cases. When adenitis is already present at the time treatment is begun, it results in spontaneous resolution in two thirds of the cases. When glands have suppurated, the author opens them with the bistoury, irrigates the wound with a five-per-cent. solution of resorcin, and dresses them with resorcin in powder. He has never observed phagedenism, but healing of buboes treated by this method has always been slow. Resorcin dressings are well supported, and only cause a burning sensation which is easily borne.

**Rapid Healing of Buboes by Injection of Iodoform in Vaseline.**—The following is the manner in which Professor Pontain proceeds: 1. Washing and antiseptis of the region by means of Van Swieten's liquid, diluted one half with hot water. 2. Puncture with the lancet if the skin is soft, with the straight bistoury if the pus is deeply situated. The puncture is small and made in the most fluctuating point; it is not necessary that the incision have a slope, for there will be no discharge in the next succeeding days. 3. Evacuation of the pus, pressing out completely all the liquid contents of the ganglion; it is indispensable to cause all that the ganglion contains to be gently and gradually pressed out, and this procedure is sometimes painful. A few injections of diluted Van Swieten's liquid are now made to wash out well the pouch. 4. Injection of iodoformized vaseline melted by heat; it is to be pressed gently in by means of a glass syringe previously charged and placed in hot water. 5. Dressing with absorbent cotton. As soon as the cavity is full of the iodoformized vaseline, a wad of cotton, soaked in cold Van Swieten's liquid, is placed over the adenitis, and kept in place with a spica. The contact of the cold congeals the vaseline, and makes a plug at the orifice of the bubo. After the first day all pain disappears, and ordinarily healing is complete without cicatrix in an average of six or seven days. It is at times necessary to renew the injections of vaseline. Out of forty-one buboes thus treated by the author, more than half were cured in less than five days. The most rebellious required twenty-three days.

**The Agents of Internal Medication of Syphilis.**—In one of his clinics Professor Fournier took up this question, which presents such a considerable interest. I have already said in one of my preceding letters that this celebrated syphilographer is not a partisan of the method of subcutaneous injections, either of soluble or insoluble preparations of mercury. The digestive and epidermic ways for the introduction of remedies remain for him the two principal means of introducing mercury on which one can and should rely.

The digestive tract is by far the most convenient, and the one which should be chosen in the great majority of cases. To which preparation of mercury should the preference be given? The author passes rapidly in review metallic mercury, formerly so much used; calomel, which has just fallen into disuse because of its salivating and diarrhœa-producing action, which is much too marked: the binoxide, the black sulphide, the acetate, the protochloride, turpeth mineral, the cyanide, the bicianide, the manganate, the biniodide, which is the only one so far enumerated which is still constantly prescribed associated with the iodide of potassium. In the more recent times the peptonate has been much praised. Professor Fournier believes that it will quickly be forgotten, for it is not a very definite compound. He makes the same objection to the tannate of mercury. As to the salicylate, he has not as yet decided upon its value. In reality there are, according to him, but two compounds of mercury which have a real value, and which he calls the two columns of treatment in syphilis; they are the protiodide and the bichloride. He thinks one should employ one or the other of these according to circumstances. The protiodide irritates readily the gums and produces salivation, especially in women. In daily doses of five centigrammes it is absolutely inoffensive in the great majority of cases, and is often so in doses of eight centigrammes in men; in eight or nine cases out of ten it is also well supported in men in daily doses of ten centigrammes on condition of their having good hygiene of the mouth, and it is even possible to carry the dose to twelve or fifteen centigrammes, and continue it for from eight to fifteen days without accident. On the other hand, women are much more sensitive to its action, and it is not rare to see a dose of five centigrammes provoke in them a true stomatitis, or at least tenderness of the gums and teeth and a certain amount of salivary flow. Above seven or eight centigrammes, intolerance is usually shown in women, and few can take over ten centigrammes for any length of time. Corrosive sublimate produces much less stomatitis and salivation than the protiodide; on the other hand, it often causes the production of a gastro-intestinal phlegmasia. It is especially the stomach which is affected. This gastralgia from bichloride is often transitory, and ceases when the medicine is stopped, but at times it leaves behind it a very rebellious dyspepsia. These inconveniences are especially noticeable in women. Hence Professor Fournier makes the rule not to give sublimate to women.

The protiodide respects the stomach in the great majority of cases, but it may cause diarrhœa. The author distinguishes two varieties of this: 1. The diarrhœa which comes on in the first few days of treatment, while the system has not yet become accustomed to its presence, and which soon disappears. 2. Intercurrent diarrhœa, which is more frequent, and which comes, no one knows why, in the middle of a course of treatment.

In *résumé*, Professor Fournier prefers the protiodide, while not employing it in an exclusive manner, because it can be given in large doses and produces very marked effects. One should, as a rule, have no absolute preference for the one or the other of these two salts. The sublimate should be given to patients who have a bad condition of the mouth, and the protiodide to gastralgics. When there is no special indication, the protiodide should be prescribed, for the buccal intolerance for the protiodide is more rare than is

the gastric intolerance for the bichloride. The sublimate can be given in the form of Van Swieten's liquid diluted with sweetened water, tea, water and rum, but, best of all, with milk. However, it is better to prescribe it in pill form associated with extract of opium, each one centigramme to the pill. The protiodide is equally well given in pill form (protiodide of mercury five centigrammes and extract of opium one centigramme for each pill). It is necessary that the pills be freshly prepared, and it is well to have incorporated with them some glycerin, so that they possess a certain degree of softness to enable their solution in the digestive tube and prevent their being passed entire with the stools. The mercury must always be taken at the moment of eating, during or just after the meal, and never fasting.

**Complications of Blennorrhagia.**—Among the curious complications of blennorrhagia recently observed in France I will call to your attention (1) the slowing of the pulse described by Dr. Arnozan, of Bordeaux; (2) ulcero-membranous stomatitis of a special aspect due to a general infection of the economy by the microbe of Neisser, and which requires for its cure cauterizations with the nitrate of silver. Dr. Octave Ménard, who has observed four cases, is convinced that it is not a simple coincidence with which we have to do here, but that there is a relation of cause and effect; however, the question, it seems to me, should call for further researches.

L. BROCCQ.

PARIS, October 10, 1889.

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## Book Reviews.

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*Wood's Medical and Surgical Monographs.* July, August, September, and October Numbers. William Wood & Co., Publishers. New York, 1889.

SINCE our last notice of this series of valuable contributions to medical literature four numbers have appeared, embracing the following titles:

Vol. III, No. 1.—Cancer and Cancerous Diseases. By Sir Spencer Wells, Bart, F. R. C. S. Cardiac Dyspnoea and Cardiac Asthma. By Dr. S. von Basch. The Influence of Menstruation and of the Pathological Condition of the Uterus in Cutaneous Diseases. By Dr. L. Grellety. Tension as met with in Surgical Practice; Inflammation of Bone; Cranial and Intracranial Injuries. By Dr. T. Bryant, F. R. C. S. Antisepsis and its Relations to Bacteriology. By Dr. J. Neudorfer.

Vol. III, No. 2.—The Treatment of Syphilis at the Present Time. By Dr. Maximilian von Zeissl. The Treatment of Inebriety in the Higher and Educated Classes. By James Stewart, B. A. Manual of Hypodermic Medication. By Dr. Bourneville and Dr. Bricon.

Vol. III, No. 3.—Congestive Neurasthenia or Nerve Depression. By E. G. Whittle, M. D. The Art of Embalming. By Benjamin Ward Richardson, M. D. The Ætiology, Diagnosis, and Treatment of Tuberculosis. By Dr. H. von Ziemssen. Psycho-therapeutics or Treatment by Hypnotism. By C. Lloyd Tuckey. Sexual Activity and the Critical Period in Man and Woman. By Dr. Louis de Séré. Index and Contents for Vol. III.

Vol. IV, No. 1.—The Influence of the Male Element upon the Female Organism. By John Brown, M. D. The Internal and External Temperature of the Human Body as Modified by Muscle Kneading. By A. Symon Eccles, M. D. The Diseases of the Breast. By Thomas Bryant, F. R. C. S.

The list of titles embraces such a number and diversity of subjects that it will, of course, be impossible within the limits of our space to analyze these monographs separately. Suffice it to say that they have been selected with judgment and an intelligent appreciation of the wants of the profession, and are all worthy of commendation. We may glance briefly at the contents of the brochures of more especial interest to dermatologists.

The July number opens with a most able and instructive essay upon "Cancer and Cancerous Diseases." The author first refers to the undoubted increase of cancerous diseases at the present day, and presents valuable evidence, based upon the statistical reports of England, Scotland, Ireland, the United States, and other countries, showing that the death-rate of cancer is now, and has for some time been, greater than the proportional increase of population. After considering the question of the possibility of checking the increase of the disease and referring to the present state of our knowledge respecting the ætiology of malignant tumors, especially the theory of their bacillary origin and nature, he approaches the more practical question involved in their surgical treatment.

The author exposes at some length the fallacy and deception of the so-called "cancer cures," and describes at length and in detail the principles of treatment and the mode of operation to be employed in the removal of cancerous growths, more especially of the breast and uterus.

In the same number will be found a study of the "Influence of Menstruation and of the Pathological Condition of the Uterus on Cutaneous Diseases." In this essay Dr. Grellety embodies the results of fifteen years' observation and experience at Vichy, demonstrating the undoubted sympathy which exists between the utero-ovarian and tegumentary systems. He endeavors to show that the occurrence of acne eruptions at puberty and the menopause is not a mere coincidence, but a phenomenon of causal connection. The eruptions which occur during the menstrual epoch are numerous and of diverse character; among others he instances "menstrual erysipelas, herpes, and various forms of erythema." Among the cutaneous disturbances due to suppression of the menses he cites urticaria, erythema nodosum, and a certain form of bullous eruption (pemphigus virginium); and, as complications of the menopause, pruritus vulvæ, intertrigo, vulvar eczema, chloasma, and various pigmentations, chromidrosis, etc.

The entire series of observations are interesting as showing the influence of uterine derangements as essential factors in the production of various forms of eruptive disturbance.

"The Treatment of Syphilis at the Present Time," by Maximilian von Zeissl, forms the initial title of the second number of Vol. III. The author gives a historical *résumé* of the treatment of syphilis from the earliest accounts to the present time, and indicates the modifications which it has undergone in the course of centuries.

Respecting the abortive treatment by excision of the chancre, he gives

conclusions, based upon his own observations and the experience of others, to the effect that this practice is condemned by its clinical results. He is equally emphatic in the condemnation of general preventive treatment, and quotes numerous authorities in confirmation of the view that general treatment, no matter how early employed, is powerless to prevent constitutional accidents or to materially modify the evolution of the disease.

As regards the question of the duration of treatment, the author is not in accord with many leading authorities; he believes that a prolonged mercurial treatment is positively pernicious. The method of treatment advocated is essentially that of the elder Zeissl, which has already been fully set forth in a previous number of this Journal.

The concluding monograph in the October number is an exhaustive study of the "Diseases of the Breast," by Thomas Bryant, F. R. C. S. Of especial interest to the dermatologist are the chapters devoted to syphilitic mastitis, morbid conditions of the nipple, eczema, ulceration, and Paget's disease. This work is admirably illustrated by numerous wood-cuts, and by four chromo-lithographic plates containing more than thirty figures.

*Traité descriptif des maladies de la peau. Symptomatologie et anatomie pathologique.* Par MM. HENRI LEOIR, professeur à la Faculté de médecine de Lille, etc., et ÉMILE VIDAL, médecin de l'Hôpital St.-Louis, etc. Ouvrage accompagné d'un atlas de 54 planches en chromolithographie. Paris : G. Masson, éditeur, libraire de l'Académie de médecine, 120, Boulevard St.-Germain, 1889.

THIS superb undertaking on the part of MM. Leloir and Vidal (the initial number of which is before us) marks a new era in dermatological literature. The numerous text-books with which our literature has been enriched within recent years are devoted chiefly to a description of the clinical features and course, the diagnosis and treatment of diseases of the skin, giving but meager and unsatisfactory details of the pathological anatomy of the lesions. In the preparation of this work Leloir and Vidal have taken a new departure, so to speak, in that the study of the pathological histology of the skin forms the most distinctive and prominent feature.

The value of microscopical study of the tissues, not only as an efficient aid in the diagnosis of certain affections of the skin, but also as throwing light upon their nature, individuality, and pathological relationships, is generally recognized, but it must be admitted that our knowledge of the pathological anatomy of many dermatoses is inaccurate and incomplete, and contained chiefly in special memoirs, with poor and unsatisfactory illustrations. As the authors say, "there does not exist a single treatise on diseases of the skin in which the histological lesions are reproduced in a satisfactory manner. In questions so difficult, a good illustration is worth more than a hundred pages of text."

The authors have accumulated a rich collection of micrographic preparations during the ten years that they have been engaged in the preparation of this atlas, which will enable them to present original plates representing the histology of almost all known forms of cutaneous affections. These plates are accurately reproduced by the chromo-lithographic process, "show-

ing the histo-chemical reactions characteristic of the greater part of the elements, with the colorations which serve to distinguish them in different degrees of their alterations or of their evolution."

The first part is devoted to achromia, acne, acrodynia, actinomycosis, ain-hum, alopecia, anaemia of the skin, atrophy of the skin, bouton de biskra, and is illustrated with six most admirable chromo-lithographs, which bear out the promise of the authors as to faithfulness and artistic excellence.

It will be observed that the different diseases are not arranged according to any methodic system of classification, but simply in alphabetical order. In the author's opinion, the knowledge of the cause and nature of diseases of the skin is not sufficiently advanced to permit of a truly philosophic classification which should be based on pathogeny. They indicate, however, three principal divisions, the scientific basis of which may be considered as definitely established: 1. Parasitic affections. 2. Dermatoneuroses, determined by the nervous system, central or peripheric. 3. Toxicodermies, embracing lesions of the skin determined by foreign substances, topical irritants, poisons, medicaments, and dermatoses engendered by toxic products elaborated by the organism.

We have thus only indicated the general character and scope of this work; with the appearance of subsequent parts we shall notice in detail the subject-matter of the text.

*Observations on Some Rare Diseases of the Skin.* By JOSEPH FRANK PAYNE, M. D. Oxon.; F. R. C. P. London; Physician to St. Thomas's Hospital; Assistant Physician to the Hospital for Diseases of the Skin, Blackfriars. With four Plates. London: Smith, Elder & Co., 15 Waterloo Place, 1889.

THE group of rare diseases of the skin treated of in this little volume comprises: 1. Granuloma fungoides. 2. Erythrasma. 3. A nodose condition of the hair. 4. Pruritus hiemalis. These observations have been previously published—the first three in "The Transactions of the Pathological Society of London," vol. xxxviii, and the last in the "British Medical Journal." As the original sources of publication are not generally accessible, they have been republished in separate form in order "to bring the rare affections here described more definitely before that section of the medical public which is particularly interested in such subjects."

The clinical features of these cases are described with clearness and that careful attention to minute details which characterize the work of our distinguished London correspondent, and accompanied with an exposition of the present state of our knowledge respecting these rare diseases of the skin.

The case of granuloma fungoides is illustrated by two admirable colored plates, exhibiting the clinical appearances of the disease, with a third plate showing the histology of the flat, red scaly patches in the earliest stages of the disease, and also of the granular tumors.

In Plate IV the threads of the micro-parasite of erythrasma, and also specimens of beaded hairs, are beautifully shown.



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